

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02221

2260

CERTIFICATE OF DEATH

Reg. Dist. No. 38

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A155 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Anne Arundel CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Crownsville		MARYLAND STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City STREET ADDRESS West Street	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 Crownsville State Hospital		COUNTY Baltimore City (If rural give location)	
3. NAME OF DECEASED (First) James (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH 3 21 1955	
S. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Unk.	8. DATE OF BIRTH 1870 ?
9. AGE last birthday 84?	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	11. KIND OF BUSINESS OR INDUSTRY Unknown	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Edward Alton	14. MOTHER'S MAIDEN NAME Mary Elizabeth Green		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk.	16. SOCIAL SECURITY NO. Unk.	17. INFORMANT & ADDRESS Hospital Records	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Coronary Thrombosis			
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic Cardiovascular Disease			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1/21/1955, to 3/21/1955, that I last saw the deceased alive on 3/21/1955, and that death occurred at 11:00 A.M. from the causes and on the date stated above.		ADDRESS (Street, city, town, state) Crownsville, Md.	
SIGNATURE <i>h Benedict, M. D.</i>		DATE SIGNED 3/22/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF 3/28/55	NAME OF CEMETERY OR CREMATORIAL Cremation	
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE <i>H. E. Eickert</i>	LOCATION (City, town, or county) (State) Crownsville, Md.	
DATE Mar 28/55	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	

RECEIVED - DEPARTMENT OF JUSTICE - WASHINGTON, D. C.

SERIAL NO. 0834 CERTIFICATE OF DEATH

SEARCHED	INDEXED
SERIALIZED	FILED
MARCH 30 1955	
FBI - WASHINGTON, D. C.	

BUREAU U. S.

MAR 30 1955

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Caroline	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Crownsville		LENGTH OF STAY 22 yrs. 10 mos.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 Crownsville State Hospital		STREET ADDRESS (If rural, give location) None listed	
3. NAME OF DECEASED: (Type or Print)	(First) Ethel	(Middle)	(Last) Armstrong
4. DATE OF DEATH	(Month) 3	(Day) 2	(Year) 1955
5. SEX: Female	6. COLOR OR RACE: Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow	8. DATE OF BIRTH: 1905?
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Housework		10b. KIND OF BUSINESS OR INDUSTRY: - - -	9. AGE last birthday: 49 ⁸ yrs.
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME: Fred Smith		14. MOTHER'S MAIDEN NAME: Unknown Mary Hubbard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO.: None	
17. INFORMANT & ADDRESS: Hospital Records		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 3 days	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 782.4 Immediate cause (a) Acute Cardiac Failure DUE TO Antecedent cause(s) Diseases or conditions, if any, (b)... giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County)	(State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <i>John Hubbard</i>			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF 3/5/55	NAME OF CEMETERY OR CREMATORIAL Union	LOCATION (City, town, or county) Goldsboro, Md. (State)
DATE REC'D BY LOCAL REG. 3-3-55	REGISTRAR'S SIGNATURE <i>KM</i>	24. FUNERAL DIRECTOR J. E. Boulaire & Greenlawn, Md.	ADDRESS

RECEIVED

MAR 8 1965

BUREAU V. S.

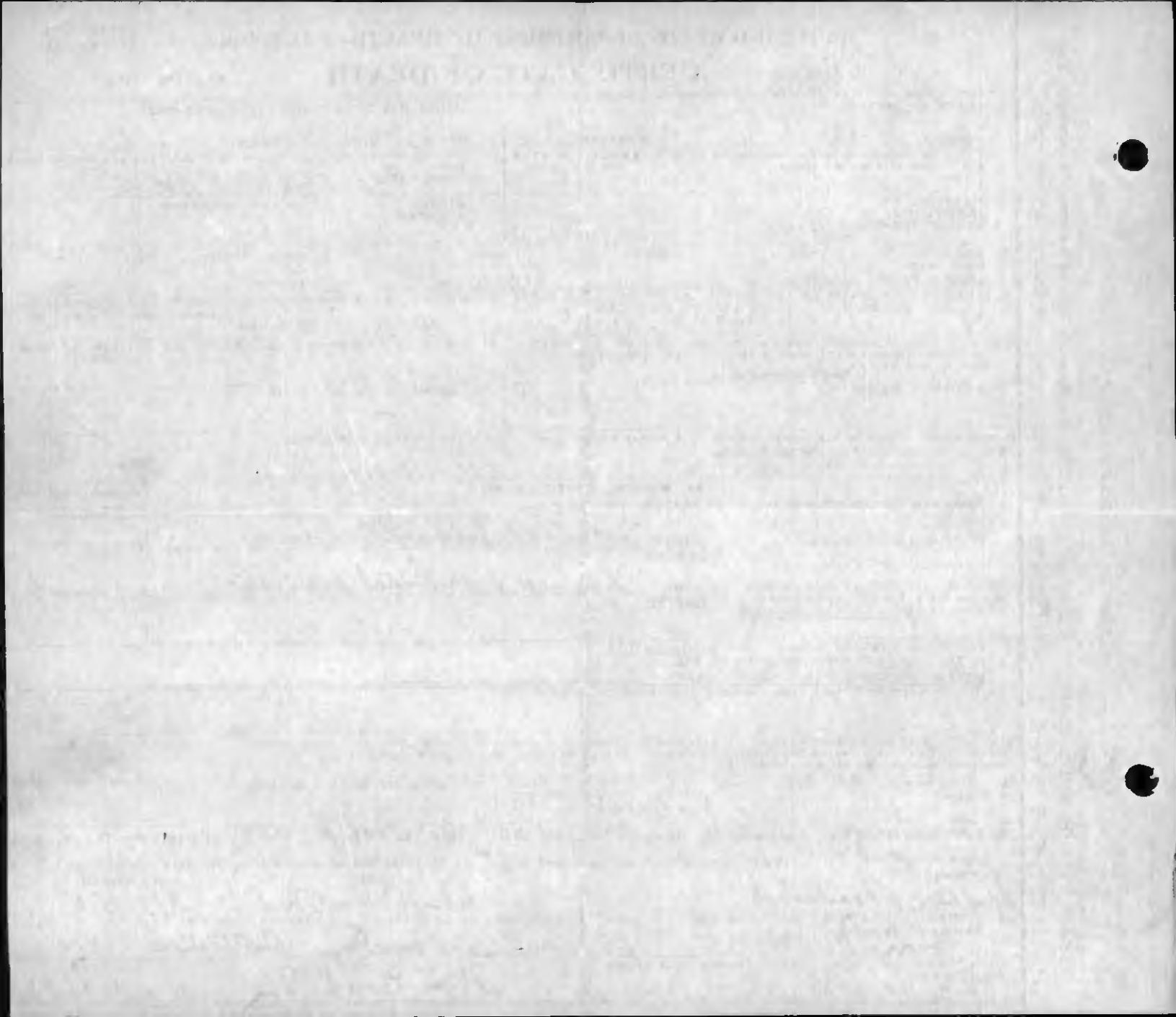
2262

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY <i>A.H.C.</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Maryland</i> COUNTY <i>A.H.C.</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>MILITTSVILLE</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>BROOKLYN PARK</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>SAHN'S NURSING HOME</i>		STREET ADDRESS <i>6020 LITCHFIELD HGT.</i>	
3. NAME OF DECEASED: (Type or Print) <i>Raymond</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>Mar 9 1955</i>	
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <i>SINGLE</i>	8. DATE OF BIRTH: <i>SEPT. 14, 1878</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life. even if retired): <i>Unknown</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>14471046</i>	
13. FATHER'S NAME: <i>—</i>		11. BIRTHPLACE (State or foreign country): <i>14471046</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>9</i>		12. CITIZEN OF WHAT COUNTRY? <i>—</i>	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT & ADDRESS: <i>Mrs. Austin 6020 LITCHFIELD HGT.</i>	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>592X</i> IMMEDIATE CAUSE <i>Mitral Insufficiency</i> ANTECEDENT CAUSE (B) <i>Chronic Subtestinal nephritis</i> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <i>—</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>+ 3 months</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>—</i>			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION <i>—</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		—	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <i>—</i>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>M.</i>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <i>—</i>		—	
22. I hereby certify that I attended the deceased from <i>Jan. 20, 1950</i> , to <i>March 9, 1955</i> , that I last saw the deceased alive on <i>March 8, 1955</i> , and that death occurred at <i>8:45 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>Frederick H. Neubauer</i> ADDRESS <i>M. D. 14471046, Baltimore, Md.</i> DATE SIGNED <i>3/9/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>3/1/55</i>	
NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) <i>St. Paul's Cemetery, Baltimore, Md.</i>		(State)	
DATE REC'D BY LOCAL REGISTRAR <i>3-10-55</i>		REGISTRAR'S SIGNATURE <i>W. H. Hedrick</i>	
24. FUNERAL DIRECTOR ADDRESS <i>Wm. Cook, Inc., 1217 E. B. Paul St.</i>			

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2237

02225

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN 10 ANNAPOLIS		MARYLAND LENGTH OF STAY (in this place)		STATE MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 10 ANNAPOLIS		COUNTY ANNE ARUNDEL (If rural give location)	
HOSPITAL OR INSTITUTION OR 13 STREET ADDRESS ANNE ARUNDEL GENERAL HOSPITAL				22 BLOOMSBURY SQUARE			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH MARCH 19 1955			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH May 2, 1901	9. AGE last birthday 53 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				11. BIRTHPLACE (State or foreign country) West Virginia			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO. 215-305703			
17. INFORMANT & ADDRESS MR. GEORGE C. BASSFORD Husband-same as #2				18. MEDICAL CERTIFICATION 199.9 IMMEDIATE CAUSE (A) Pneumothorax (pleural or?) ANTECEDENT CAUSE(S) DUE TO Carcinomatosis DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH 8 hrs 7 min.			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office, bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 19, 1954, to March 19, 1955, that I last saw the deceased alive on 3/19/1955, and that death occurred at 5:30 A.M. from the causes and on the date stated above. SIGNATURE <i>Frank M. Shifley</i> M.D. ADDRESS (Street, city, town, state) <i>Annapolis, Md.</i> DATE SIGNED <i>3/20/55</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF March 21, 1955		NAME OF CEMETERY OR CREMATORIAL Glen Haven Memorial Cemetery		LOCATION (City, town, or county) Glen Burnie, Maryland (State)	
24. REC'D BY REGISTRAR DATE March 21, 1955		REGISTRAR'S SIGNATURE <i>J. D. Duncal</i>		25. FUNERAL DIRECTOR'S SIGNATURE HOPING FUNERAL HOME ADDRESS ANNAPOLIS, MD.			

DEPARTMENT OF INTERNAL AFFAIRS
PROVINCIAL GOVERNMENT OF QUEBEC

CERTIFICATE OF DEATH

DEATH CERTIFICATE
NO. 1234567890

DEATH CERTIFICATE NO. 1234567890

DEATH CERTIFICATE NO. 1234567890

DEATH CERTIFICATE NO. 1234567890

DEATH CERTIFICATE NO. 1234567890

BUREAU V. S.

MR. J. J. J.

RECEIVED

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2238

CERTIFICATE OF DEATH

02226

Reg. Dist. No. 21

Item 7. Film 0179 4-7-55 et

1. PLACE OF DEATH

COUNTY	Anne Arundel	MARYLAND	STATE	Maryland	COUNTY	Anne Arundel
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)	Annapolis	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	Green Haven, PASADENA, Md.	COUNTY	Anne Arundel
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Anne Arundel General	STREET ADDRESS	(If rural give location)	Outing Ave. & 2nd St.		

3. NAME OF
DECEASED
(Type or Print)

John

(none)

Bialozynski
BIALOZYNSKI

4. DATE (Month) (Day) (Year)

March 27, 1955

5. SEX

6. COLOR OR
RACE7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

8. DATE OF BIRTH

9. AGE last birthday

10. IF UNDER 1 YEAR
Months Days Hours Min.

Male

White

Single

Unknown

68?

yrs. Months Days Hours Min.

10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

Handyman

10b. KIND OF BUSINESS
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT
COUNTRY?

Home Improvement

Unknown

13. FATHER'S NAME

John Bialozynski

14. MOTHER'S MAIDEN NAME

Josephine Prosinska

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unk.)

(If Yes, give war or dates of service)

Unk.

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

Mrs. Martin Sass Camp Meade Rd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0 IMMEDIATE CAUSE

(A)

DUE TO

ANTECEDENT CAUSE(S)
DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

(D)

DUE TO

(E)

DUE TO

(F)

DUE TO

Pulmonary Edema

INTERVAL BETWEEN
ONSET AND DEATH

4 Hours

Arteriosclerotic Heart Disease

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

M. at work at work 22. I hereby certify that I attended the deceased from 3/27, 1955, to 3/27, 1955, that I last saw the deceased
alive on 3/27, 1955, and that death occurred at 9:45 P.M. from the causes and on the date stated above.

SIGNATURE

Edward J. Beck

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county)

(State)

Burial

April 1, 1955

Holy Cross Cem.

Anne Arundel Co., Md.

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE

4/1/55

Wm. J. French

George J. Horne 4001 Ritchie Hwy.

2000-01-001

Referencia bibliográfica

Digitized by srujanika@gmail.com

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Lungfishes (Sarcopterygii)

180 *Journal of Health Politics*

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230

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APC

REGELV. L.

2263 MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

02227

Reg. Dist. No. 23

1. PLACE OF DEATH COUNTY Anne Arundel		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MARYLAND	
CITY (If outside corporate limits, write RURAL and OR give nearest town) X TOWN Glen Burnie		LENGTH OF STAY (In this place) 4 years.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Point Pleasant		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glen Burnie Street Glen Burnie	
3. NAME OF DECEASED (Type or Print) Charles A. Boone Jr.		4. DATE OF DEATH March 28 1955	
5. SEX M.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 7/2/07
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter for Keystone Lumber Service		9. AGE last birthday 47 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore - Md.	
12. FATHER'S NAME Charles A. Boone		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. MOTHER'S MAIDEN NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 218-09-8184	
(If yes, give war or dates of service)		17. INFORMANT AND ADDRESS Mrs. N. Boone (Wife)	
18. MEDICAL CERTIFICATION			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.
Immediate cause

(a) *Coronary Occlusion*

INTERVAL BETWEEN
ONSET AND DEATH
sudden

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause
stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. FUNDAMENTAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		PLACE (Home, farm, factory, street, of office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month)	(Day)	(Year)	INJURY OCCURRED at	HOW DID INJURY OCCUR?	
m.			While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		

22. I certify that I took charge of the remains described above; held an Autopsy, Inspection Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes accident suicide homicide undetermined.

SIGNATURE

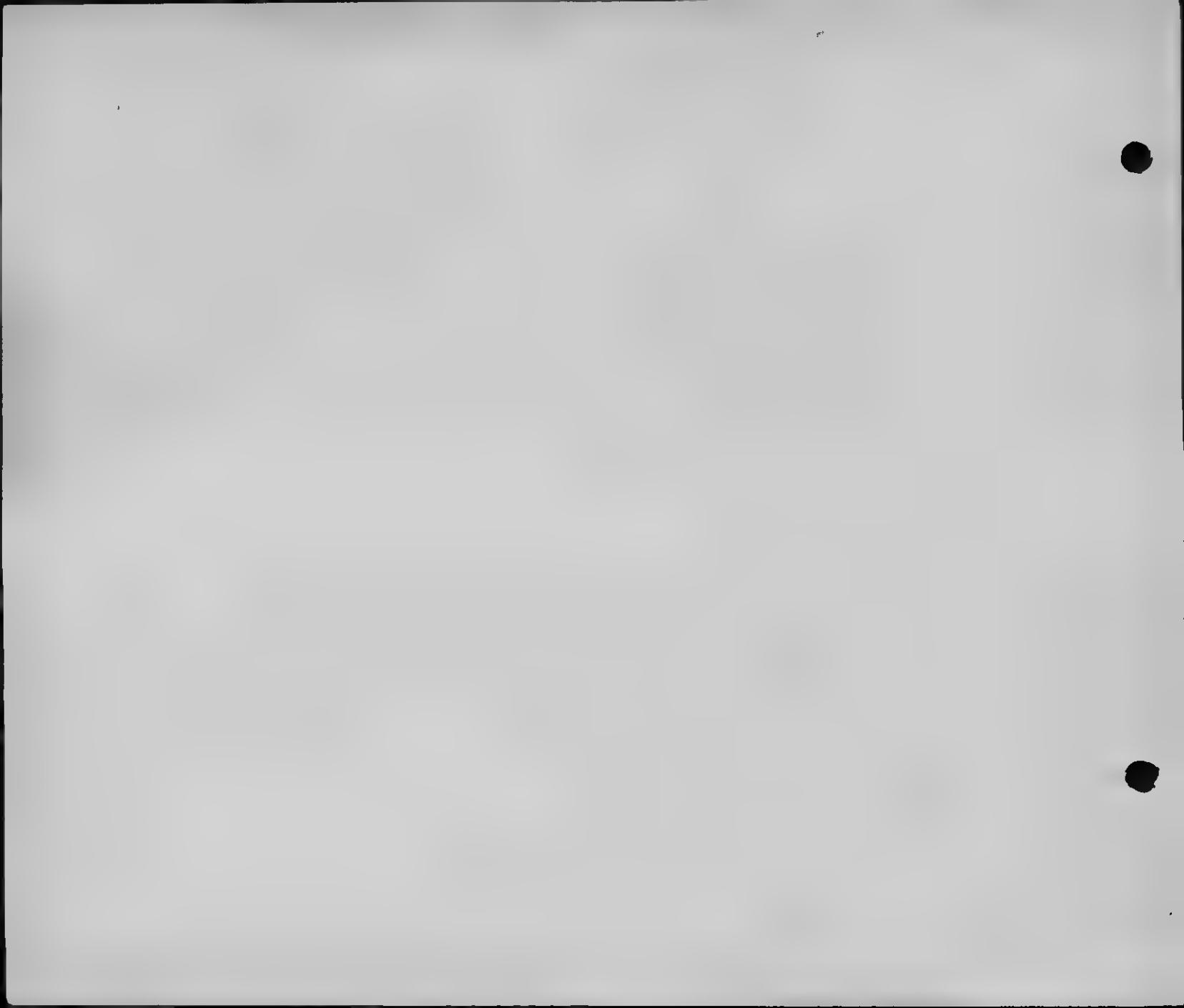
(Degree or title)

ADDRESS

DATE SIGNED

3/28/55

19c. CREMATION Serial	DATE THEREOF 3/30/55	NAME OF CEMETERY OR Crematory London Ck.	LOCATION (City, town, or county) Baltimore, Md.	(State)
DATE REC'D BY LOCAL REGISTRARS SIGNATURE REG 3-29-55		23. FUNERAL DIRECTOR ADDRESS John J. Lichten & Sons, Baltimore, Md.		



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician, and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2239

02228

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (In this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY STREET ADDRESS (If rural give location)
10 A.A. ANNAPOLIS	MARYLAND 10	MD ANNAPOLIS	A.A. 104 MARKET
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last)		3 - 10 1955	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED MARRIED	8. DATE OF BIRTH 1-19-1881
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MILLER	10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY ACADEMY	11. BIRTHPLACE (State or foreign country) PA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
F. W. ALBERT BRENEMAN		JANE SMITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS	
		CYNTHIA M. BRENEMAN	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 5-18 IMMEDIATE CAUSE (A) Cerebral Vascular Accident		INTERVAL BETWEEN ONSET AND DEATH 10 minutes	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Arteriosclerosis, generalized GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		unknown	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M. 3-10-55 10:00 A.M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1 Jan 1955, to 10 Mar 1955, that I last saw the deceased alive on 10 Mar 1955, and that death occurred at 10:00 A.M. from the causes and on the date stated above. SIGNATURE Edward S. Beck M.D. ADDRESS (Street, city, town, state) 49 Southgate Ave Annapolis 3-1055 DATE SIGNED			
23. BURIAL, Cremation, REMOVAL (SPECIFY) Burial		DATE THEREOF 3-10-55	NAME OF CEMETERY OR CREMATORIUM New Harmony Cemt
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE J. O. Connel	LOCATION (City, town or county) York Co. Penn
DATE March 11, 1955		25. FUNERAL DIRECTOR'S SIGNATURE John W. Taylor & Sons Annapolis	



CERTIFICATE OF DEATH

Reg. Dist. No. 22

Item 12, File # 4-1b-53 et

1. PLACE OF DEATH

COUNTY Anne Arundel

MARYLAND

X CITY (If outside corporate limits, write RURAL and
OR give nearest town)
TOWN JessupLENGTH OF STAY
(in this place)
6 monthsHOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Maryland House of Correction

3. NAME OF
DECEASED
(Type or Print)

(First) Charles

(Middle)

(Last) Brown

4. SEX

male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED.
(Specify)

married

5. DATE OF BIRTH

Dec. 25. 1900

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Painter

10b. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (State or foreign country)

Chile

12. CITIZEN OF WHAT
COUNTRY?

Unknown

13. FATHER'S NAME

Unknown

14. MOTHER'S MIDDLE NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of
service)

yes

World War I

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS

Mc House of Correction

18. MEDICAL CERTIFICATION

19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151X Immediate cause

Antecedent cause(s)

Diseases or conditions, if any,

giving rise to the above cause

stating the underlying cause last

(a) *Carcinoma of Stomach with
metastases*

(b)

(c)

(d)

(e)

20. AUTOPSY?

Yes No

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)

INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)

OF INJURY

INJURY OCCURRED

While at Work Not While At work

How did injury occur?

m. Work At work

DATE SIGNED

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

VS. A15

22. I hereby certify that I attended the deceased from 8-15

alive on 3-6-1955, and that death occurred at 6:45 A.M.

from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

326

2265 CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH

COUNTY	Anne Arundel		
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	
TOWN	Crownsville		9mos. 17days
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Crownsville State Hospital		

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE	Maryland	COUNTY	Caroline
CITY (If outside corporate limits, write RURAL and give nearest town)		STREET ADDRESS	
TOWN	Greensboro		(If rural give location)

05X-2

3. NAME OF
DECEASED
(Type or Print)

(First) Dennis (Middle) Brown (Last)

4. DATE (Month) (Day) (Year)
OF DEATH 3 8 1955

5. SEX

Male

6. COLOR OR
RACE

Negro

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) WIDOW

8. DATE OF BIRTH

3/4/1891

10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

Unemployed

10b. KIND OF BUSINESS
OR INDUSTRY

- - - -

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT
COUNTRY?

U. S.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of service)
UNK.

UNK.

16. SOCIAL SECURITY NO.
2019-14-4906
Unk.

17. INFORMANT & ADDRESS

Hospital Records

18. MEDICAL CERTIFICATION

443X IMMEDIATE CAUSE

(A)

Myocardial Insufficiency

ANTECEDENT CAUSE(S) DUE TO
DISEASES OR CONDITIONS, IF ANY, (B)
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO
(C)

Hypertensive cardiovascular Disease

INTERVAL BETWEEN
ONSET AND DEATH

5 weeks

19a. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19b. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
M. at work Not while
at work

21f. HOW DID INJURY OCCUR?

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BUREAU V. S.

MAR 16 1955

INSTRUCTIONS

PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VII A15C 1-55 10th

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02231

26

2266 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Anne Arundel CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Shady Side		MARYLAND LENGTH OF STAY (in this place) 25 yrs	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 50		STATE MD COUNTY AA CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shady Side STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
Thomas		3rd 5th 1955	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH MAY 4 1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Faymer		10b. KIND OF BUSINESS OR INDUSTRY Tobacco	11. BIRTHPLACE (State or foreign country) Churchton
13. FATHER'S NAME Robert H. Bussey		14. MOTHER'S MAIDEN NAME Lucenie Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS Mrs Katherine F. Schmick		12. CITIZEN OF WHAT COUNTRY? ARNOLD MD	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 150x		IMMEDIATE CAUSE (A) Hemorrhage - esophageal ANTECEDENT CAUSE(S) DUE TO (B) Carcinoma - esophagus DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)	
		INTERVAL BETWEEN ONSET AND DEATH 18Hrs 6 Mos	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION 11		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) Shady Side, Maryland (County) Baltimore (State) MD			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 12-14, 1954, to 3-4, 1955 , that I last saw the deceased alive on 3-4, 1955 , and that death occurred at 1:30 A.M. from the causes and on the date stated above. 3-5-55			
SIGNATURE J. D. Hendricks		ADDRESS Shady Side, Maryland DATE SIGNED 3-5-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3/7/55 NAME OF CEMETERY OR CREMATORIAL 202 KER LOCATION (City, town, or county) Lindesville MD (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Ade Belle Deats FUNERAL DIRECTOR'S SIGNATURE Bernard Hardisty, Glensville ADDRESS	
DATE Mar. 9, 1955			

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached and used as a burial permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2267

CERTIFICATE OF DEATH

02232

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
CITY Anne Arundel OR and nearest town TOWN Crownsville		STATE Maryland COUNTY Baltimore City CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital		STREET ADDRESS (If rural give location) 439 W. Henrietta Street	
3. NAME OF (First) Mary (Middle) Frances (Last) Carr (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH 3 5 55	
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH 1884?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY - - -	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT & ADDRESS Hospital Records		18. MEDICAL CERTIFICATION Known to us since 3/3/55	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 600.0 IMMEDIATE CAUSE (A) Uremia ANTECEDENT CAUSE(S) DUE TO Chronic Pyonephrosis DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Gangrenous urinary cystitis		II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile Brain Disease	
19a. DATE OF OPERATION - - -		19b. MAJOR FINDINGS OF OPERATION - - -	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) White Not white at work at work	
21e. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from... 3/3 alive on 3/5, 19 55, and that death occurred at 12:30 P.M. from the causes and on the date stated above. SIGNATURE L. Benedict, M. D. ADDRESS (Street, city, town, state) Crownsville, Md. DATE SIGNED 3/5/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Buried		DATE THEREOF 3/10/55 NAME OF CEMETERY OR CREMATORIAL Mt. Auburn LOCATION (City, town, or county) Baltimore, Maryland (State)	
24. REC'D BY REGISTRAR DATE 3/9/55		REGISTRAR'S SIGNATURE C. W. Stroh, Jr. ADDRESS 25. FUNERAL DIRECTOR'S SIGNATURE Charles G. Stroh, Jr. ADDRESS	

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician. **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155-10H
TICKET NUMBER: 2240

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2240 CERTIFICATE OF DEATH

02233

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Anna Arundel CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN Annapolis, 10		MARYLAND LENGTH OF STAY (In this place)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anna Arundel General Hospital		STATE Md. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Riderwood, 3X-2	
3. NAME OF DECEASED (Type or Print) Stuart M. Christhlf		STREET ADDRESS W. Joppa Road	
4. DATE (Month) OF DEATH March 16, 1955		(If rural give location)	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Nov. 4, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Distributor - Construction & Industrial		9. AGE last birthday 65 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY Equipment		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Henry B. Christhlf		14. MOTHER'S M AIDEN NAME Anna M. O. Gill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS Mr. Bryson Christhlf 1708 Circle Road Ruxton-4, Md.		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 443 X IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO (A) Rupture of dissecting aortic aneurysm DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) Atherosclerosis of aorta STATING UNDERLYING CAUSE LAST. DUE TO (C) Arterosclerotic Hypertension and		INTERVAL BETWEEN ONSET AND DEATH — 5 yrs. 5 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M. at work		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3/1/55, to 3/16/55, that I last saw the deceased alive on 3/16/55, and that death occurred at 3:25 P.M. from the causes and on the date stated above.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE HEREOF NAME OF CEMETERY OR CREMATORIUM March 19, 1955 Druid Ridge	
24. REC'D BY REGISTRAR DATE 3/21/55		REGISTRAR'S SIGNATURE	
25. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons 1900 Eutaw Place		ADDRESS	
John O. Mitchell & Sons 1900 Eutaw Place		(State)	

—S. K. AVERILL

8.00

—S. K. AVERILL

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-155 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2268 CERTIFICATE OF DEATH

02234

Reg. Dist. No. 24

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY ARUNDEL CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN POWHATAN BEACH 6 yrs.		STATE MARYLAND COUNTY ANNE ARUNDEL CITY (If outside corporate limits, write RURAL and give nearest town) TOWN POWHATAN BEACH	
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.I.D. 3 PASADENA		STREET ADDRESS R.I.D. 3 PASADENA	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
HOMER BUTTS CLARK (First) (Middle) (Last)		March 2 1955	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) WIDOWED	8. DATE OF BIRTH
M	W	Feb. 19, 1877 (3) approximately 78	AGE last birthday
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
CARPENTER		TRANSIT Co.	Virginia
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Clark.		Judith Hammond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None	
17. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
420. IMMEDIATE CAUSE (A) MYOCARDIAL INFARCTION (B) ARTERIOSCLEROTIC HEART DISEASE 2 years (C)		DUE TO ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	
19a. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		19b. DATE OF OPERATION	
19c. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 9:15 P.M. from the causes and on the date stated above.		ADDRESS (Street, city, town, state) 102 BALTIMORE AVNW. BLDV. GLEN BURNIE M.D. DATE SIGNED 3/2/1955	
SIGNATURE John TAZER		M.D.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 3-5-55 NAME OF CEMETERY OR CEMETORY Loudon Park LOCATION (City, town, or county) BALTIMORE MD. (State)	
24. REGD BY REGISTRAR		REGISTRAR'S SIGNATURE Louis J. Doherty ADDRESS	
DATE Mar. 6, 1955		25. FUNERAL DIRECTOR'S SIGNATURE George L. Schwab ADDRESS 2108 Fullerton Ave.	

5 3 11 11 11
BL 12511



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2270

CERTIFICATE OF DEATH

02236

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY A.A. CITY (If outside corporate limits, write RURAL OR give nearest town) TOWN Pt. Pleasant		MARYLAND LENGTH OF STAY (in this place)		STATE Md CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pt. Pleasant		COUNTY A.A. (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) Barbara Mary Cunningham				4. DATE OF DEATH 3 3 55			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH 12/22/90	9. AGE last birthday 64 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Michael J. Zant				14. MOTHER'S MAIDEN NAME Barbara M. Wise			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) No		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS Family - Same			
18. MEDICAL CERTIFICATION							
<p>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 1. 35 IMMEDIATE CAUSE (A) <u>Carcinomatosis</u> ANTECEDENT CAUSE(S) (B) <u>Carcinoma Colon</u> DUE TO DISEASES OR CONDITIONS, IF ANY, (C) <u>1 year</u> GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. </p>							
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</p>							
19a. DATE OF OPERATION 7		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) Mar (Day) 19 (Year) 55 (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<p>22. I hereby certify that I attended the deceased from <u>Mar. 9, 55</u>, to <u>March, 19, 55</u>, that I last saw the deceased alive on <u>2-26-55</u>, and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.</p> <p>SIGNATURE <u>John Mac Donald</u> M.D. ADDRESS (Street, city, town, state) <u>1814 Burrue Md</u> DATE SIGNED <u>3-3-55</u></p>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) B		DATE THEREOF 3/8/55		NAME OF CEMETERY OR CREMATORIUM Cathedral		LOCATION (City, town, or county) Baltimore (State) <u>Md.</u>	
24. REGD. BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Leahay</u>		25. FUNERAL DIRECTOR'S SIGNATURE James L. McCully - 130 E. Fort Ave.		ADDRESS	
DATE Mar. 7, 1955							

SAVANNAH

1000

1000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2271 CERTIFICATE OF DEATH

Reg. Dist. No. 12237

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEDENT:	
COUNTY <u>Anne Arundel</u> MARYLAND CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town) TOWN <u>Owl-1801-194 Millersville 15 mos.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Owl</u>		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Owl-1801-194 Millersville P.O. Box</u> STREET ADDRESS <u>(If rural give location)</u>	
3. NAME OF DECEASED: <u>Agnes</u> (First) <u>MATILDA</u> (Middle) <u>DAHL</u> (Last) (Type or Print)		4. DATE OF DEATH: <u>MARCH 15</u> (Month) <u>1955</u> (Year)	
5. SEX: <u>Female</u> 6. COLOR OR RACE: <u>White</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u> 8. DATE OF BIRTH: <u>June 3, 1898</u> 5-6		9. AGE at birthday: <u>56</u> (If UNDER 1 YEAR yrs. <u>Months</u> <u>Days</u> Hours <u>Min.</u>)	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Fee 10a</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>A.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service): <u>No</u>		16. SOCIAL SECURITY NO.: <u>215-14-8517</u> 17. INFORMANT & ADDRESS <u>Howard Dahl Jr. Addeess - Same</u>	
18. MEDICAL CERTIFICATION Interval Between Onset And Death			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>260X</u> <u>Pulmonary Edema</u> 3 hrs Immediate cause <u>Diabetes Mellitus</u> 5 yrs. Antecedent causes (s) <u>Essential Hypertension</u> 3 yrs. Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.			
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Obesity</u> 15 yrs.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE		(Specify) PLACE (Home, farm, factory, street, of office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3/15/1955</u> to <u>3/15/1955</u> that I last saw the deceased alive on <u>3/15/1955</u> and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Richard D. Burnie</u> ADDRESS <u>315-15-15</u> DATE SIGNED <u>3/15/1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/18/55</u> NAME OF CEMETERY OR CEMATORIUM <u>Old Home Private Cemetery</u> LOCATION (City, town, or co. <u>Allegany Co.</u> state)	
DATE REC'D BY LOCAL REGISTRAR <u>March 17, 1955</u>		REGISTRAR'S SIGNATURE <u>D. M. Joyce</u> 24. FUNERAL DIRECTOR <u>W. D. Engleton</u> ADDRESS <u>Allegany Co.</u>	
L. J. Della		L. J. Della	

Y. S. 1954

1860-1861

2241

MARYLAND STATE DEPARTMENT OF HEALTH

02238

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Annapolis</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Linden</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>158-2</u>	
3. NAME OF DECEASED (Type or Print)	First) <u>Richard</u>	(Middle) <u>Ralph</u>	(Last) <u>Davis</u>
4. DATE OF DEATH	(Month) <u>3</u>	(Day) <u>24</u>	(Year) <u>1955</u>
5. SEX	6. COLOR OR RACE <u>Male</u> <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>Sept. 23, 1914</u>
9. AGE last birthday yrs.	10. OCCUPATION (Give kind of work done during most of working life, even part-time) <u>Bull Dozer Operator</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN COUNTRY <u>A.S.A.</u>
13. FATHER'S NAME <u>Eliphas</u> <u>Brown</u>	14. MOTHER'S MAIDEN NAME <u>Georganna Davis</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Y, N, or unknown) <u>Y</u> <u>Wife</u>	
16. SOCIAL SECURITY NO. <u>44-12-1212</u>		17. INFORMANT AND ADDRESS <u>Elizabeth Davis - Linden, Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

2105

Immediate cause

Fracture Cervical Vert. C ComprexxINTERVAL BETWEEN
ONSET AND DEATH

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause lastJ. Paul

Hudden

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY

Yes No

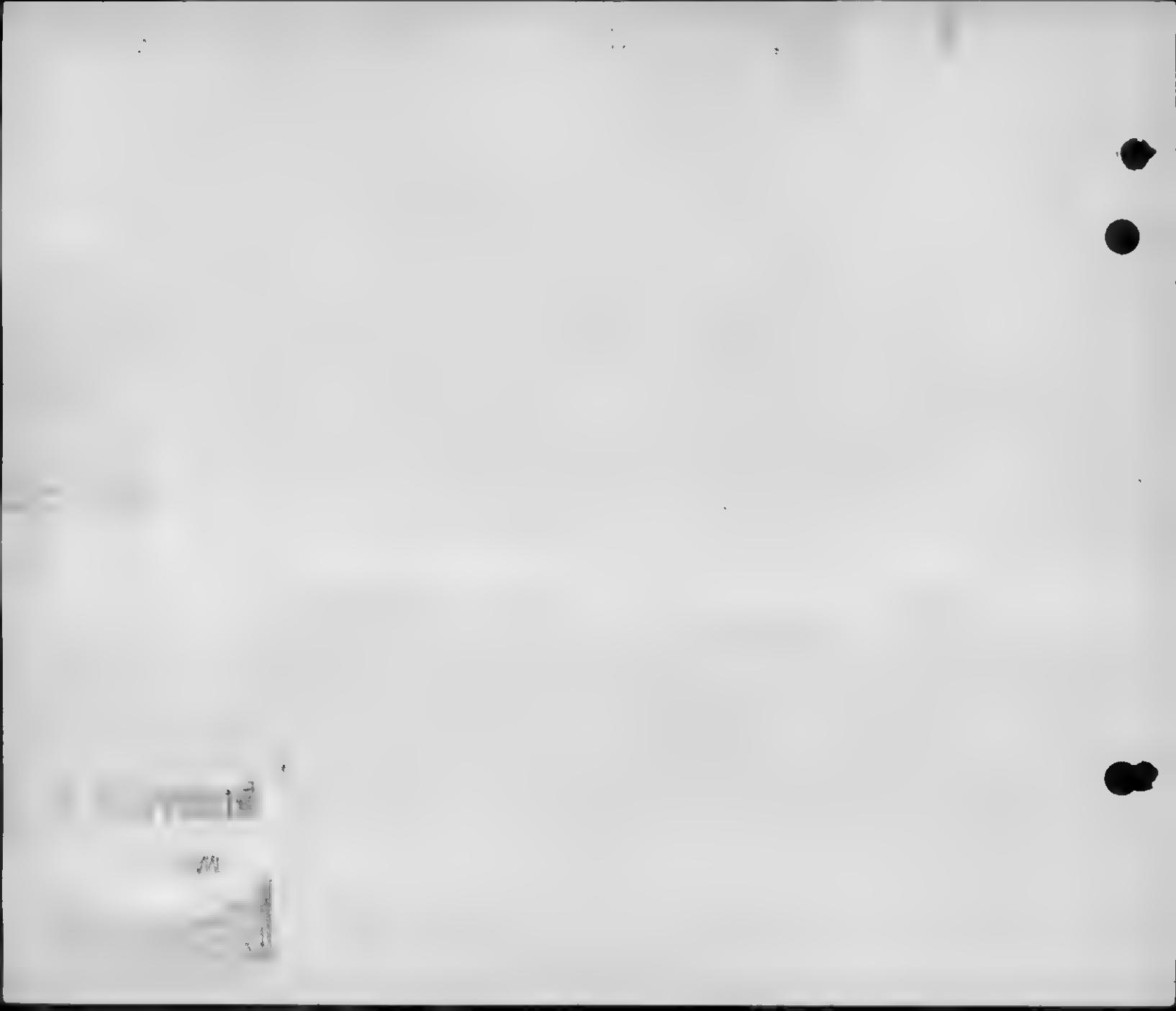
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY <u>Highway</u>	(CITY OR TOWN) <u>Arlington</u>	(COUNTY) <u>Arlngt</u>	(STATE) <u>MD</u>	
TIME (Month) (Day) (Year) OF INJURY <u>3 24 55</u>	(Hour) P.m. <u>P</u>	INJURY OCCURRED While at <input checked="" type="checkbox"/> Not while work <input type="checkbox"/> at work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Free fall - on patient</u>		

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry thereon and from the evidence obtained by Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes accident suicide homicide undetermined

SIGNATURE

(Degree or title) Richard LaddtDATE SIGNED 3/24/55

23. Cremation REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3-28-1955</u>	NAME OF CEMETERY OR CREMATORY <u>Burial</u>	LOCATION (City, town, or county) <u>Arlington, Va.</u>
DATE REC'D BY LOCAL REG. <u>March 25, 1955</u>	REGISTRIES SIGNATURE <u>J. French</u>	24. FURNAL DIRECTOR <u>William Laddt</u>	ADDRESS <u>Annapolis, Md.</u>



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02239

2272

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH

COUNTY Anne Arundel
 CITY (If outside corporate limits, write RURAL
 OR and give nearest town)
 TOWN Crownsville
 HOSPITAL OR
 INSTITUTION OR
 STREET ADDRESS
 10 Crownsville State Hospital

MARYLAND

LENGTH OF STAY
 (In this place)
 4 yrs. 7 mos. 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Baltimore City
 CITY (If outside corporate limits, write RURAL and give nearest town)
 TOWN Baltimore City
 STREET ADDRESS
 1713 Pierce Street
 (If rural give location) 34614

3. NAME OF
 DECEASED
 (Type or Print)

Emma

4. DATE
 OF
 DEATH

(Month) (Day) (Year)

3 3 1955

5. SEX

6. COLOR OR
 RACE

Female Negro

10e USUAL OCCUPATION (Give kind of work
 done during most of working life, even if
 retired) None7. SINGLE, MARRIED,
 WIDOWED, DIVORCED,
 (Specify)

Separated

8. DATE OF BIRTH

9/11/04

9. AGE last birthday

50

yrs.

IF UNDER 1 YEAR
 Months Deyrs Hours Min.10b. KIND OF BUSINESS
 OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT
 COUNTRY?

U. S.

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
 (Yes, no, or unk.) (If Yes, give war or dates of service)

Unk.

Unk.

16. SOCIAL SECURITY NO.

Unk.

17. INFORMANT & ADDRESS

Hospital Records

18. MEDICAL CERTIFICATION

INTERVAL BETWEEN
 ONSET AND DEATH

420.0 IMMEDIATE CAUSE

(A) Arteriosclerotic Heart disease

Several years

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST. DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING

TO THE DEATH BUT NOT RELATED TO THE

DISEASE OR CONDITION CAUSING DEATH

Epilepsy

Known to us since
 7/26/50

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
 (If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
 OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

M. While at work

Not while at work

3 4 5 6 7 8 9

1 2 3 4 5 6 7 8 9

INSTRUCTIONS

TO ATTENDING PHYSICIAN **HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VI AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02240

2273 CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN end give nearest town) X Crownsville		MATERIAL LENGTH OF STAY (In this place) 24 days		STATE Maryland		COUNTY Maryland Dorchester	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 13 Crownsville State Hospital				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rhodesdale STREET ADDRESS R. F. D.			
3. NAME OF DECEASED (Type or Print) Parley				4. DATE (Month) OF DEATH 3 6 19 55			
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 11/4/95	9. AGE last birthday 59 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY ---			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Moses Ferrell				14. MOTHER'S MAIDEN NAME Alonza Ferrell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk.				16. SOCIAL SECURITY NO. Unk.			
17. INFORMANT & ADDRESS Hospital Records				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 443X IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				Known to us since 2/10/55 Cerebral Vascular Accident Hypertension and Arteriosclerotic cardiovascular disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION ---		19b. MAJOR FINDINGS OF OPERATION ---		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) ---		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) ---			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? ---			
22. I hereby certify that I attended the deceased from 2/10, 19 55, to 3/6, 19 55, that I last saw the deceased alive on 3/6, 19 55, and that death occurred at 12:20 P.M. from the causes and on the date stated above. SIGNATURE <i>John Ferrell</i> ADDRESS (Street, city, town, state) Crownsville, Md. 3/6/55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) 3/9/55		DATE THEREOF 3/9/55		NAME OF CEMETERY OR CREMATORIAL Thompsonstown Cemetery		LOCATION (City, town, or county) Thompsonstown, Maryland (State)	
24. REC'D BY REGISTRAR DATE 3-7-55		REGISTRAR'S SIGNATURE K. M. Ferrell		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert M. Sallenger, Esq. 1/1/55			

THE NEWTON

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INSTRUCTIONS

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02242

2274 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH

COUNTY Anne Arundel
 CITY (If outside corporate limits, write RURAL
 OR and give nearest town)
 TOWN Winchester

HOSPITAL OR
 INSTITUTION OR
 STREET ADDRESS
00

MARYLAND

LENGTH OF STAY
(In this place)

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Anne Arundel
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR
 TOWN Winchester

STREET
 ADDRESS
 (If rural give location)

3. NAME OF
 DECEASED
 (Type or Print)

(First) Carrie (Middle) Bersch (Last) Fischer

4. DATE (Month) (Day) (Year)

3 12 1955

5. SEX F6. COLOR OR
 RACE White7. SINGLE, MARRIED,
 WIDOWED, DIVORCED,
 (Specify) Widow8. DATE OF BIRTH
Nov. 26, 18679. AGE last birthday
87 yrs.10. USUAL OCCUPATION (Give kind of work
 done during most of working life, even if
 retired) Housewife10b. KIND OF BUSINESS
 OR INDUSTRY11. BIRTHPLACE (State or foreign country)
Maryland12. CITIZEN OF WHAT
 COUNTRY? USA

13. FATHER'S NAME

Carl Bersch

14. MOTHER'S MAIDEN NAME

Angelica Bude15. WAS DECEASED EVER IN U. S. ARMED FORCES?
 (Yes, no, blank.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

Mrs. Gerda Vey #2

18. MEDICAL CERTIFICATION

19a. IMMEDIATE CAUSE

(A) Embolism to Brain, rt. undelticallyINTERVAL BETWEEN
 ONSET AND DEATH

5 days

ANTECEDENT CAUSE(S)

DUE TO

DISEASES OR CONDITIONS, IF ANY,
 GIVING RISE TO THE ABOVE CAUSE
 STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

Arteriosclerosis CCO20. AUTOPSY?
 YES NO

19b. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21a. ACCIDENT WAS UNDERLYING
 OR CONTRIBUTING CAUSE OF DEATH
 (If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
 OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
 While Not while
 at work at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1955 to 3/12/1955, that I last saw the deceased
 alive on 3/12/1955, and that death occurred at 8:05 P.M. from the causes and on the date stated above.

SIGNATURE

Frank M. Shulley

ADDRESS (Street, city, town, state)

DATE SIGNED

3/14/55

23. BURIAL, CREMATION,
 REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county)

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE March 14, 1955J. O. Daniels John M. Taylor Sons Annapolis Md

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. S.

MAR 15 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02243

2275

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	AA	MARYLAND	STATE MD COUNTY AA
CITY (If outside corporate limits, write RURAL OR end give nearest town)	LENGTH OF STAY (In this place)		
TOWN Nutwell	63 yrs		
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS		
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last)		MAR 11 1955	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Male	White	MARRIED	OCT 13 1871
9. AGE last birthday	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
83	Tobacco	TRACYS MD	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Robert	FRANCES Perry		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.		
NO	none		
17. INFORMANT & ADDRESS			
Susie R Ford, Nutwell, MD			
18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>arterial disease</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerosis</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Arteriosclerosis</i>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Arteriosclerosis</i>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1955</i> , 19.20., to <i>1955</i> , 19.21., that I last saw the deceased alive on <i>1955</i> , 19.22., and that death occurred at <i>5:30 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>John J. B. Jr.</i> ADDRESS <i>1417 N. Charles St., Baltimore, Md.</i> DATE SIGNED <i>1955</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIUM	LOCATION (City, town, or county) (State)
Burial	3/13/55	Friendship	Friendship MD
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	
DATE 3/12/55	John J. B. Jr.	Bernard Hardisty, G. L. Well, Jr.	

INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filed in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

15 MAR 1955

15 MAR 1955

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10/M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2276

CERTIFICATE OF DEATH

02244

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY

CITY (If outside corporal limits, write RURAL
OR and give nearest town)

TOWN

RIVA

MARYLAND

LENGTH OF STAY
(in this place)

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

CITY (If outside corporal limits, write RURAL and give nearest town)

TOWN

HILLSMERE STORES

COUNTY

A A

(If rural give location)

ANNAPOLIS R.F.D. MD 1

3. NAME OF
DECEASED
(Type or Print)

(First)

(Middle)

(Last)

SADIE

R. FULTON

4. DATE
OF
DEATH

(Month)

(Day)

(Year)

3 - 30 1955

5. SEX

6. COLOR OR
RACE7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

8. DATE OF BIRTH

9. AGE last birthday

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
part-time)10b. KIND OF BUSINESS
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

18. MEDICAL CERTIFICATION

19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X IMMEDIATE CAUSE

(A)

ANTECEDENT CAUSE(S)

DUE TO

DISEASES OR CONDITIONS, IF ANY,

(B)

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST,

DUE TO

(C)

20. AUTOPSY?

YES NO

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

(If either, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

M.

21e. INJURY OCCURRED

While at work Not while at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from.....

alive on.....

SIGNATURE

3/13/55

1955 to.....

3/13/55

1955, that I last saw the deceased

and that death occurred at.....

2:00 P.M.

from the causes and on the date stated above.

ADDRESS (Street, city, town, state)

Annapolis Md

DATE SIGNED

3/30/55

Pa

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

Removal

24. REC'D BY REGISTRAR

March 31, 1955

Edward Collier

John M. Taylor

Sons of Annapolis Md

1955

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2277

02245

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		MARYLAND		STATE Maryland		COUNTY Baltimore City	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL end give nearest town)		TOWN Baltimore City	
TOWN Crownsville		4 mos. 8 days		TOWN Baltimore City		9Y01-4 (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 Crownsville State Hospital		STREET ADDRESS 652 W. Franklin Street					
3. NAME OF DECEASED (First) Leetta (Middle) Evelyn (Last) Gibbs				4. DATE (Month) (Day) (Year) DEATH 3 24 1955			
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced	8. DATE OF BIRTH 8/15/11	9. AGE last birthday 43 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. DAYS	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				11. BIRTHPLACE (State or foreign country) Ohio			
10b. KIND OF BUSINESS OR INDUSTRY Unknown				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Mack Preston				14. MOTHER'S MAIDEN NAME Rosetta Ealy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk.				16. SOCIAL SECURITY NO. Unk.			
17. INFORMANT & ADDRESS Hospital Records				18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 782.4 IMMEDIATE CAUSE (A) Acute heart failure ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, ■ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH 2 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) M, at work			
21c. WHERE DID INJURY OCCUR? (City or town) Crownsville, Md.				(County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M, 3/24/55 5:30 a.m.				21e. INJURY OCCURRED While at work			
21f. HOW DID INJURY OCCUR? From the causes and on the date stated above.							
22. I hereby certify that I attended the deceased from 11/16, 1954, to 3/24, 1955, that I last saw the deceased alive on 3/24, 1955, and that death occurred at 5:30 a.m. from the causes and on the date stated above. SIGNATURE (L. Benedict, M. D.) ADDRESS (Street, city, town, state) Crownsville, Md. DATE SIGNED 3/24/55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3/28/55	NAME OF CEMETERY OR CREMATORIUM Mt Auburn Cem.		LOCATION (City, town, or county) Baltimore, Md. (State)		
24. REC'D BY REGISTRAR DATE 3/25/55		REGISTRAR'S SIGNATURE Katherine M. Joyce		25. FUNERAL DIRECTOR'S SIGNATURE A. H. Benedict, Jr.		ADDRESS Crownsville, Md.	

RESCUE

RESCUE

MR

INSTRUCTIONS

TO ATTACHEE The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2278

02246

28

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Anne Arundel CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Crownsville		MARYLAND STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 Crownsville State Hospital		LENGTH OF STAY (in this place) STREET ADDRESS 1810 Etting St.	
3. NAME OF DECEASED (Type or Print) Annie Gray		4. DATE (Month) (Day) (Year) OF DEATH March 26 19 55	
5. SEX Female	6. COLOR OR RACE No ro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH 10/12/78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 76 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME unk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. unk	
17. INFORMANT & ADDRESS hospital Record		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 443X IMMEDIATE CAUSE (A) Cerebrovascular Accident (Hemorrhage)		INTERVAL BETWEEN ONSET AND DEATH 9 days	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Hypertensive & Arteriosclerotic Cardiovascular D's.		years	
DUE TO (C) Generalized & Cerebral Arteriosclerosis		years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR? ---	
22. I hereby certify that I attended the deceased from 2/16/55, 19, to 3/ 26, 19 55, that I last saw the deceased alive on 3/26, 19 55, and that death occurred at 6:30 a.m., from the causes and on the date stated above. SIGNATURE <i>Stanley P. Sargent, M.D.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) - 1a1		DATE HEREOF Mar 30/55	
24. REC'D BY REGISTRAR DATE 3/29/55		NAME OF CEMETERY OR CREMATORIUM New Cathedral Cemetery Baltimore REGISTRAR'S SIGNATURE Dakota M. Joyce	
		LOCATION (City, town, or county) Crownsville, Md.	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Vic Brooks Puggold 1463 N. Carey			

DELLA V. S.

NR.

DEAN

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2279

02247

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY Anne Arundel		MARYLAND	STATE Maryland		COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN Crownsville		LENGTH OF STAY (in this place) 11 mos. 29 days	CITY (If outside corporate limits, write RURAL end give nearest town) TOWN Baltimore City		3101-4
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital			STREET ADDRESS 1718 W. Lafayette Street		
3. NAME OF DECEASED (First) Jeanette (Middle) S. (Last) Green			4. DATE (Month) (Day) (Year) OF DEATH 3 2 1955		
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH 12/5/74	9. AGE last birthday 80 yrs.	IF UNDER 1 YEAR Months — Deyrs — Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Music Teacher			11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME Thomas J. Hilliard			14. MOTHER'S MAIDEN NAME Harriet N. Hilliard		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <input checked="" type="checkbox"/> UNK. (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. Unk.		
17. INFORMANT & ADDRESS Hospital Records			18. MEDICAL CERTIFICATION Generalized Arteriosclerosis		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 450.0 IMMEDIATE CAUSE (A) DUE TO ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH Known to us since 3/4/54		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		
21c. WHERE DID INJURY OCCUR? (City or town)			(County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED M. While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		
21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 3/4, 1954, to 3/2, 1955, that I last saw the deceased alive on 3/2, 1955, and that death occurred at 4:20 A.M., from the causes and on the date stated above.					
BENEDICT, DR. (Dr. Benedict)			ADDRESS (Street, city, town, state) Crownsville, Md.		
DATE SIGNED 3/2/55			DATE SIGNED 3/2/55		
23. BURIAL CEMETERY (Specify) Mt. Calvary			NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State) Baltimore City, Maryland		
24. REC'D BY REGISTRAR DATE Mar. 8, 1955			REGISTRAR'S SIGNATURE Matthew M. Dyer		
25. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips 1808 N. Monroe St. Balt. 17, Md.			ADDRESS		

RECEIVED

MAR 8 1955

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2280 MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02248

CERTIFICATE OF DEATH

Reg. Dist. No. 21

Item 8, File 3179 4-1-55 et

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
Anne Arundel MARYLAND		Anne Arundel MD	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
X Hanover		Hanover Rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
Elbridge Landing Rd		Elbridge Landing Rd	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last)		(Month) (Day) (Year)	
Rachel Maria Greene		Mar 22 1955	
5. SEX		6. COLOR OR RACE	
Female Col		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Domestic		Housewife	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Nicholas Greene		Anne Waters	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		none	
17. INFORMANT AND ADDRESS			
Elzenea Shandy, 10th and 5th, Hanover, Md.			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
4221			
Immediate cause (a) <u>Chronic Myocarditis</u>			
Antecedent cause(s) (b) <u>Compensation</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Deformity</u>			
<u>Arteritis</u>			
<u>Sclerosis</u>			
<u>Senility</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
19c. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	
m.		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 20, 1955</u> , to <u>Mar 22, 1955</u> , that I last saw the deceased alive on <u>Mar 21, 1955</u> , and that death occurred at <u>2 25 p.m.</u> , from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF	
Burial		3/25/1955	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR		ADDRESS	
Elbridge A. W. Hedrick		Mrs. Katie R. Williams	
Elbridge		Schneider St.	



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2242

02249

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH

COUNTY Anne Arundel

MARYLAND

CITY (If outside corporate limits, write RURAL
OR
and give nearest town)

TOWN Annapolis, Maryland

LENGTH OF STAY
(in this place)

2 days

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland

COUNTY AA

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Annapolis, Md.

(If rural give location)

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

U.S. Naval Hospital, Annapolis

STREET
ADDRESS

29 Badger Road

3. NAME OF
DECEASED
(Type or Print)

(First)

(Middle)

(Last)

William

Arthur

GREGORY

4. DATE (Month) (Day) (Year)
OF DEATH March 6 1955

5. SEX

6. COLOR OR
RACE

M

C

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

M

8. DATE OF BIRTH

9-11-28

9. AGE last birthday

27 26 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

USN

10b. KIND OF BUSINESS
OR INDUSTRY

USN

11. BIRTHPLACE (State or foreign country)

S.C.

12. CITIZEN OF WHAT
COUNTRY?

USA

13. FATHER'S NAME

William Arthur Gregory Sr.

14. MOTHER'S MAIDEN NAME

Agnes Jeffers Stackhouse

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unk.) (If Yes, give war or dates of service)

Yes

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

U.S.N.H Records

18. MEDICAL CERTIFICATION

INTERVAL BETWEEN
ONSET AND DEATH

Ind.

19a. IMMEDIATE CAUSE (A)

Tumor, Brain (#193) Ependymoma

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST. DUE TO

(C)

19b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19c. DATE OF OPERATION

19d. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY straat, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While
M. at work Not white
at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from

3-7-1955 to 3-7-1955

, that I last saw the deceased

alive on 3-7-1955, and that death occurred at 8:40M, from the causes and on the date stated above.
SIGNATURE: *R.H. Brown* ADDRESS (Street, city, town, state) DATE SIGNED
R.H. BROWN LDR MC USN 3-6-5523. BURIAL, CREMATION,
REMOVAL (SPECIFY)
REMOVAL

DATE THEREOF

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county) (State)

M.D. USNH, Annapolis, Md.

GRIFFIN, GA.

24. REC'D BY REGISTRAR
DATE 3-7-1955

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

B.L. Hopping and Son Annapolis, Md.

12. 121

01

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155-10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02250

2243

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN 10 ANNAPOULIS	MARYLAND LENGTH OF STAY (In this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS 138 CHARLES	COUNTY 11
HOSPITAL OR INSTITUTION OR STREET ADDRESS 63 A.A. GENERAL HOSP	12.		
3. NAME OF (First) (Type or Print) ELLEN KEY HABERSHAM	(Middle)	(Last)	4. DATE (Month) (Day) (Year) 3 - 10 1955
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED SINGLE	8. DATE OF BIRTH Nov. 23-1870 84
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY HOME	9. AGE last birthday 11. BIRTHPLACE (State or foreign country) BALTIMORE MD 21234
13. FATHER'S NAME ALEXANDER WILLY HABERSHAM		12. CITIZEN OF WHAT COUNTRY U.S.A	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. ~	14. MOTHER'S MAIDEN NAME JESSIE STEELE
17. INFORMANT & ADDRESS MRS FOSTER HANNAFORD		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 162x IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		TRACHEAL OBSTRUCTION Malignancy of TRACHEA Carcinoma of TRACHEA OBSTRUCTION	
INTERVAL BETWEEN ONSET AND DEATH SECONDS		SEVERAL MONTHS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION 10 MARCH 1955		19b. MAJOR FINDINGS OF OPERATION Tumor of TRACHEA (Carcinoma)	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7 MARCH 1955, to 11 MARCH 1955, that I last saw the deceased alive on 10 MARCH 1955, and that death occurred at 11:30 A.M. from the causes and on the date stated above. SIGNATURE J. B. Reddy			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3/17/55	NAME OF CEMETERY OR CREMATORIAL St. James Burying Ground
24. REC'D BY REGISTRAR DATE March 14, 1955		REGISTRAR'S SIGNATURE J. J. Donald	LOCATION (City, town, or county) Annapolis Md
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John M. Taylor Sons Annapolis Md			

RECEIVED

MAR 15 1975

BROWN

2281

02251

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY Anne Arundel

MARYLAND

CITY (If outside corporate limits, write RURAL LENGTH OF STAY
OR and give nearest town) (in this place)

All life

TOWN Severn

HOSPITAL OR
INSTITUTION OR

STREET ADDRESS Queenstown Road

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Same

COUNTY Same

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Same

STREET ADDRESS

(If rural give location)

Same

3. NAME OF
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

Edward

Hall

March 15

19 55

4. SEX:

5. COLOR OR
RACE:6. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR
IF UNDER 24 HRS

M.

Colored

Widowed?

8

yrs. Months Day Hour Min.

10a. USUAL OCCUPATION Give kind of
work done during most of working life,
even if Retired labor.10b. KIND OF BUSINESS OR
INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT
COUNTRY?

Severn, Md.

U.S.A.

13. FATHER'S NAME:

Jerry Hall

14. MOTHER'S MAIDEN NAME:

Lille Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service) No

16. SOCIAL SECURITY NO.:

No

17. INFORMANT & ADDRESS:

Asahall Hall (son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X

Immediate cause

(a) DUE TO

Hypertensive cardio vascular diseases

Interval Between
Onset And Death

Antecedent causes (s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last.

(b) DUE TO

Acute prostatitis

?

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No 21. ACCIDENT (Specify) PLACE (Home, farm, factory, street,
SUICIDE of office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)22. I hereby certify that I attended the deceased from 3/2/55, 19, to 3/15/55, 19, that I last saw the deceased
alive on 3/10/55, 19, and that death occurred at 8 A.M., from the causes and on the date stated above.
SIGNATURE (Degree or title) ADDRESS DATE SIGNED

3/15/55

23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR CREMATORIUM LOCATION (City, town, or county) (State)

REMOVAL (Specify) 3/15/1955 Mt Calvary Brooklyn - Maryland

DATE REC'D BY LOCAL REGISTRAR REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS

MARSHALL P. HAYES 638 N. BELMONT



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2244

02252

CERTIFICATE OF DEATH

21

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Anne Arundel MARYLAND		STATE Maryland COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Annapolis		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 76 Franklin Street		STREET ADDRESS (If rural give location) 76 Franklin Street	
3. NAME OF DECEASED (First) CARRIE (Middle) OLIVIA (Last) MARDESTY		4. DATE (Month) (Day) (Year) OF DEATH 3/14/1955	
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH March 6, 1933
9. AGE at birthday 52 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Galesville A.A. Co. Maryland
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME James Turner	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Annapolis, Maryland Walter Hardesty-76 Franklin Street	
18. MEDICAL CERTIFICATION <i>Carcinoma of the Recto-Sigmoid Portion of the Large Intestine</i> INTERVAL BETWEEN ONSET AND DEATH 1 year			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
21b. PLACE (Home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 12</u> , 1955, to <u>March 13</u> , 1955, that I last saw the deceased alive on <u>3/14</u> , 1955, and that death occurred at <u>4:50 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Richardson</u> ADDRESS (Street, city, town, state) <u>110 - Clay Street Annapolis, Maryland</u> DATE SIGNED <u>3/14/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF <u>Mar 15, 1955</u> NAME OF CEMETERY OR CREMATORIUM <u>Brewer Hill Cemetery</u> LOCATION (City, town or county) <u>West St. Annapolis, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>March 15, 1955</u>		REGISTRAR'S SIGNATURE <u>O'Donnell</u> 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Ethel L. Hicks - 45 Northwest St. Annapolis</u>	

January 28

MAR 16 1955

W. G. - 11



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-5-10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2245

02253

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY A A		MARYLAND		STATE MD COUNTY A A	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)	
10 TOWN Annapolis		1 day		OR TOWN Galesville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS	
11 Anne Arundel General				(If rural give location)	
3. NAME OF (First) OSCAR (Middle) Emile (Last) Hortge (Type or Print)			4. DATE (Month) (Day) (Year) OF DEATH March 30 1955		
5. SEX Male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH Aug 9 1875	9. AGE last birthday 79 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine Captain		10b. KIND OF BUSINESS OR INDUSTRY MARINE		11. BIRTHPLACE (State or foreign country) Shadyside MD	
13. FATHER'S NAME Emile Alexander Hortge			14. MOTHER'S MAIDEN NAME SUSAN V. Edgar		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. 388 20 5087		17. INFORMANT & ADDRESS Susan V. Edgar Strong Galesville MD	
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Diabetic coma			INTERVAL BETWEEN ONSET AND DEATH 12 hr.		
IMMEDIATE CAUSE Diabetic coma ANTECEDENT CAUSE(S) DUE TO Myocardial infarction?			INTERVAL BETWEEN ONSET AND DEATH 12 hr.		
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY—street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) Galesville (State) MD	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3/29/1955 to 3/30/1955 , that I last saw the deceased alive on 3/30/1955 , and that death occurred at 5:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city, town, state) Annapolis DATE SIGNED 3/30/55					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3/30/55		NAME OF CEMETERY OR CREMATORIAL Zucker LOCATION (City, town, or county) Galesville (State) MD	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE J. Frazee		25. FUNERAL DIRECTOR'S SIGNATURE Bernard Hartung ADDRESS Galesville	
DATE April 1, 1955					

• *W. B. D. G.*

• *1868*

• *-0*

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2246

02254

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN		MARYLAND LENGTH OF STAY (in this place)		STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
10. ANNAPOLIS		MD		COUNTY ANNAPOLIS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS		(If rural give location)	
11. A.A. GENERAL		DEFENCE HIGHWAY		10	
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
C. ADDISON HODGES			3 - 28 1955		
5. SEX Male	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, SPECIFY MARRIED	8. DATE OF BIRTH 4-3-1885	9. AGE last birthday 69	10. IF UNDER 1 YEAR Yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if part-time)			11. BIRTHPLACE (State or foreign country)		
PROBATION OFFICER			A.A. Co. MD		
13. FATHER'S NAME JOHN THOMAS HODGES			12. CITIZEN OF WHAT COUNTRY U.S.A.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		
(If Yes, give war or dates of service)			17. INFORMANT & ADDRESS John H. HODGES, DAVIDSONVILLE MD		
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 540.1 IMMEDIATE CAUSE (A) <u>peritonitis</u> ANTECEDENT CAUSE(S) DUE TO <u>rupture + necrosis transverse colon</u> 18 days DISEASES OR CONDITIONS, IF ANY, (B) <u>gastric ulcer</u> GIVING RISE TO THE ABOVE CAUSE DUE TO <u>gastric ulcer</u> STATING UNDERLYING CAUSE LAST. (C)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION Mar. 15 a. 26 55		19b. MAJOR FINDINGS OF OPERATION gastric ulcer, 2 necrosis transverse colon		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) John H. HODGES, DAVIDSONVILLE MD (County, State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12-13 1955</u> to <u>3-28 1955</u> , that I last saw the deceased alive on <u>3-27 1955</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above SIGNATURE <u>South Roseller</u> ADDRESS (Street, city, town, state) <u>M.D. 45 Franklin St. Annapolis Md 3-28-55</u> DATE SIGNED					
23. BURIAL, CREMATION, REMOVAL (SPECIES) Burial		DATE THEREOF Mar. 29 1955		NAME OF CEMETERY OR CREMATORIAL All Hallows Chapel Davidsonville Md	
24. REC'D BY REGISTRAR John H. HODGES		REGISTRA'S SIGNATURE John H. HODGES		25. FUNERAL DIRECTOR'S SIGNATURE John W. Taylor Sons Annapolis Md.	
DATE <u>March 29, 1955</u>					



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-51 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2282

CERTIFICATE OF DEATH

02255

28

Item 9, FilmG178 3-16-55 et

Reg. Dist. No. 28

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Anne Arundel CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Gambrills		LENGTH OF STAY (in this place) STREET ADDRESS (If rural give location) "Rose Hill"	
HOSPITAL OR INSTITUTION OR STREET ADDRESS "Rose Hill"		STATE Maryland COUNTY Anne Arundel CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gambrills	
3. NAME OF		4. DATE (Month) (Day) (Year)	
(First) (Type or Print) MATILDA		(Middle) DARE HOPKINS	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Female	White	Single	April 30, 1880
9. AGE last birthday	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
74 1/2 yrs.	House wife	Gambrills, Maryland	USA
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Samuel Snowden Hopkins		Matilda Elizabeth Matilda	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS	
(Yes, no, or unk.)	none	Mr. C. Edward Hopkins, same as # 2	
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		19. MEDICAL CERTIFICATION	
170x IMMEDIATE CAUSE (A) <i>Alimentary carcinoma - Lt Breast</i>		INTERVAL BETWEEN ONSET AND DEATH 6 MO	
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. DATE OF OPERATION		21b. MAJOR FINDINGS OF OPERATION	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Oct. 1, 1946, to Oct. 1, 1947</i> , that I last saw the deceased alive on <i>Oct. 1, 1955</i> , and that death occurred at <i>9:40 A.M.</i> from the causes and on the date stated above. <i>Edward G. Ernest</i> M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF March 3, 55	NAME OF CEMETERY OR CREMATORIAL St. Stephens Cemetery
24. REC'D BY REGISTRAR DATE 3-4-55		REGISTRAR'S SIGNATURE <i>John J. Hopping</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>John J. Hopping and Son, Inc., Millersville, Md.</i>

W. V. V. V. V. V.

1955 3 10

1955 3 10

CERTIFICATE OF DEATH

Reg. Dist. No. 345

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>ANNE ARUNDEL</u> MARYLAND		STATE <u>MD.</u> COUNTY <u>ANNE ARUNDEL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR give nearest town TOWN <u>ROUTE #3- ANNAPOLIS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ROUTE #3- ANNAPOLIS</u>	
LENGTH OF STAY (in this place) <u>2 WKS.</u>		STREET ADDRESS (If rural give location) <u>Wild Rose Shores.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wild Rose Shores.</u>			
3. NAME OF DECEASED: (First) <u>Ada</u>		(Middle) <u>Louise</u>	
(Last) <u>Hoye</u>		4. DATE (Month) <u>MARCH</u> (Day) <u>8th</u> (Year) <u>1955</u>	
5. SEX: <u>FEMALE</u>		6. COLOR OR RACE: <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH: <u>FEB 7/ 1871</u>	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country): <u>Flat Rock, Mich.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>GEORGE MILTON READING</u>		14. MOTHER'S MAIDEN NAME: <u>Florence MIGHES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>George G. Hoye-Route #3- Annapolis, Md.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>i51X</u> Immediate cause (a) <u>Possible Gastric Carcinoma</u> Interval Between Antecedent causes (s) DUE TO Onset And Death Diseases or conditions, if any, giving rise to the above cause (b) _____ stating the underlying cause last. DUE TO _____ (c) _____			
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY ? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, of office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> HOW DID INJURY OCCUR? <u>m.</u>	
22. I hereby certify that I attended the deceased from <u>3-8</u> , 1955, to <u>3-8</u> , 1955, that I last saw the deceased alive on <u>3-8</u> , 1955, and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Edward Beck Jr.</u> (Degree or title) <u>ADDRESS</u> <u>DATE SIGNED</u>			
23. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify) <u>Burial</u> <u>3/11/1955</u>		NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or County) (State) <u>Cedar Hill Cemetery, Annapolis, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR REGISTER 1955 <u>3/11/55</u>		24. FUNERAL DIRECTOR ADDRESS <u>W.W. CHAMBERS Co - Riverdale Md.</u>	
REGISTRAR'S SIGNATURE <u>John Severy</u>		- O. French	

3

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10A

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2247 CERTIFICATE OF DEATH

02257

Reg. Dist. No. 21

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY <i>AA Co.</i>		MARYLAND		STATE <i>Md</i> COUNTY <i>AA Co.</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)	
10 TOWN <i>ANNA Polis</i>			STREET ADDRESS		<i>ANNA Polis</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00 35 Bunch St</i>				35 Bunch St	
3. NAME OF DECEASED (Type or Print) <i>ELIA</i>			4. DATE OF DEATH <i>3 8 55</i>		
(First) <i>ELIA</i>		(Middle) <i>JACKSON</i>		(Month) <i>3</i> (Day) <i>8</i> (Year) <i>55</i>	
5. SEX <i>Female Colored</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>W</i>	8. DATE OF BIRTH <i>7-29-1895</i>	9. AGE last birthday <i>69 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md</i>	
13. FATHER'S NAME <i>George Moulton</i>			14. MOTHER'S MAIDEN NAME <i>FANNIE SMITH</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>George Moulton 35 Bunch St</i>	
18. MEDICAL CERTIFICATION					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>442x</i> IMMEDIATE CAUSE <i>Arteriosclerosis by extension</i>					
ANTECEDENT CAUSE(S) DUE TO <i>Cardiac arrest</i>					
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE DUE TO <i>Thrombosis</i>					
STATING UNDERLYING CAUSE LAST. DUE TO <i>None</i>					
INTERVAL BETWEEN ONSET AND DEATH <i>11 months</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>None</i>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) <i>None</i> (County) <i>None</i> (State) <i>None</i>	
21d. TIME OF INJURY (Month) <i>Mar</i> (Day) <i>8</i> (Year) <i>1955</i> (Hour) <i>10</i>		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>None</i>	
22. I hereby certify that I attended the deceased from <i>Mar 8 1955</i> to <i>Mar 8 1955</i> , that I last saw the deceased alive on <i>Mar 8 1955</i> , and that death occurred at <i>11:49 AM</i> , from the causes and on the date stated above. SIGNATURE <i>George Moulton</i> ADDRESS (Street, city, town, state) <i>None</i> DATE SIGNED <i>3/9/55</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>3-11-55</i>		NAME OF CEMETERY OR CREMATORIAL <i>None</i> M.D. <i>None</i> LOCATION (City, town, or county) <i>ANNA Polis Md</i> (State) <i>None</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>None</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>None</i> ADDRESS <i>ANNA Polis Md</i>	
DATE <i>3-10-55</i>		REGISTRAR'S SIGNATURE <i>None</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>None</i> ADDRESS <i>ANNA Polis Md</i>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

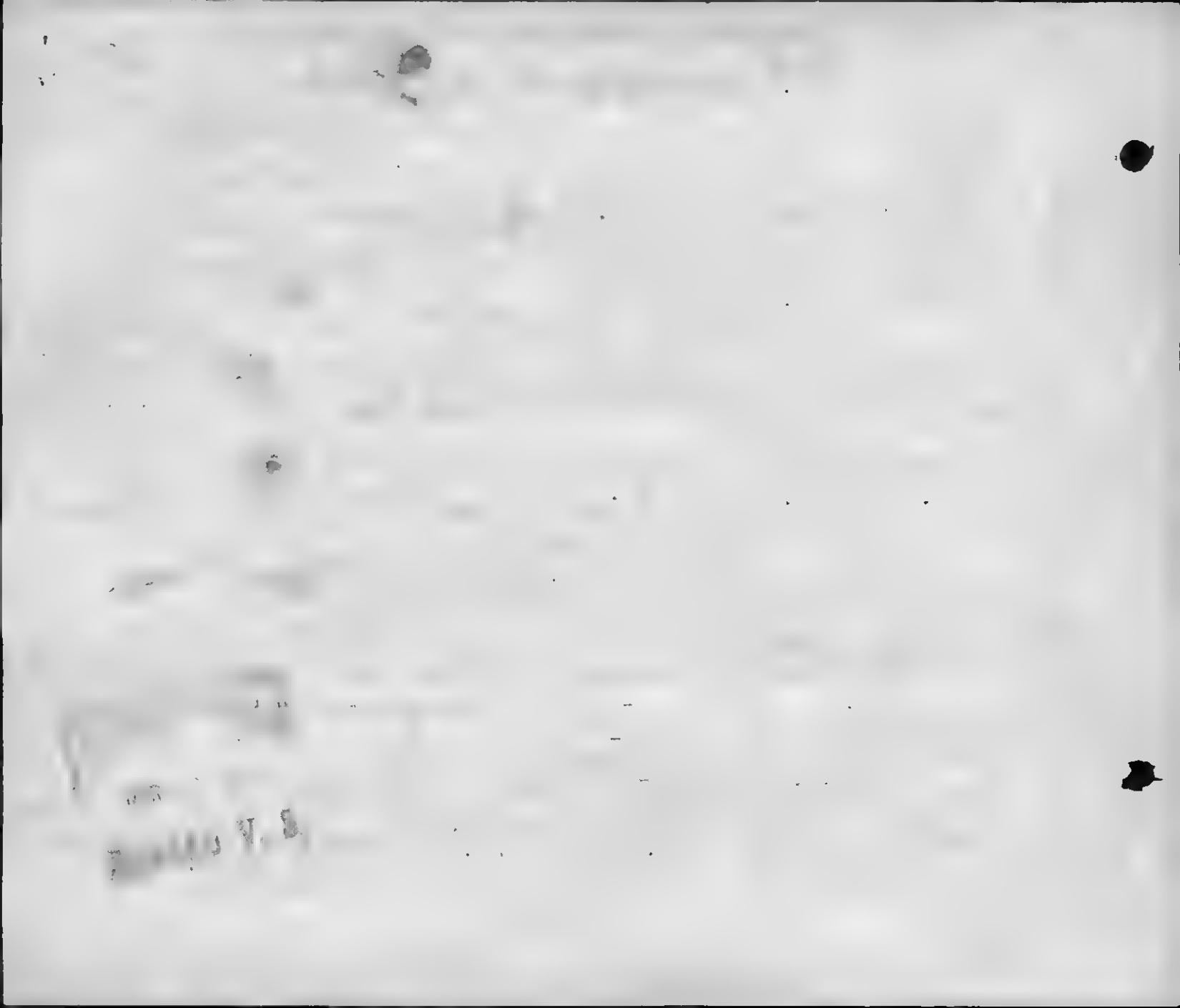
2284

CERTIFICATE OF DEATH

02258

Reg. Dist. No. 28

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)	Anne Arundel Crownsville	MARYLAND LENGTH OF STAY (in this place)	Maryland Cambridge
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10	2 mos. 16 days		STREET ADDRESS 58 Douglas Street (If rural give location)
Crownsville State Hospital		Dorchester	
3. NAME OF DECEASED (First) Philip (Middle) Jenkins (Type or Print)		4. DATE OF DEATH 3 16 1955	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single	8. DATE OF BIRTH 1880?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	9. AGE last birthday 752 yrs. IF UNDER 1 YEAR Months — Days — Hours — Min. —
13. FATHER'S NAME Unknown		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk.		16. SOCIAL SECURITY NO. Unk.	12. CITIZEN OF WHAT COUNTRY? U. S.
17. INFORMANT & ADDRESS Hospital Records		14. MOTHER'S MAIDEN NAME Isabella Jenkins	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (A) Coronary Thrombosis (B) Arteriosclerotic Cardiovascular Disease		Known to us since 12/30/54	
INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) 00	(County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 12/30, 1954, to 3/16, 1955, that I last saw the deceased alive on 3/16, 1955, and that death occurred at 1:50 a.m., from the causes and on the date stated above.			
SIGNATURE <i>L. Benedict, M. D.</i>		ADDRESS (Street, city, town, state) Crownsville, Md.	DATE SIGNED 3/16/55
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 3/19/55	NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery	LOCATION (City, town, or county) Cambridge, Maryland
24. REC'D. BY REGISTRAR DATE 3/18/55	REGISTRAR'S SIGNATURE A. W. Benedict, Jr.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. H. Stetson per Chas. Gandy 317 High Street Cambridge Md.	



INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2285

02259

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH

COUNTY *A R*
 CITY (If outside corporate limits, write RURAL
OR and give nearest town)
 TOWN *Errolsville*

MARYLAND

LENGTH OF STAY
(in this place)
14 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE *MD*
 COUNTY *AA*
 CITY (If outside corporate limits, write RURAL and give nearest town)
 TOWN *Errolsville*

STREET ADDRESS
(If rural give location)
*1*3. NAME OF
DECEASED
(Type or Print)(First) *Agnes*

(Middle)

(Last)

*Johnson*4. DATE (Month)
OF
DEATH(Day) (Year)
MAR 19 1955

5. SEX

*F*6. COLOR OR
RACE*C*7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)*widow*

8. DATE OF BIRTH

Aug 25

9. AGE last birthday

*64*IF UNDER 1 YEAR
Months Days Hours Min. 10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)*Housewife*10b. KIND OF BUSINESS
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

*Birdsville MD*12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME

Benji Dunn SR.

14. MOTHER'S MAIDEN NAME

Isabell Simms

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unk.)

(If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT & ADDRESS

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151X IMMEDIATE CAUSE *(A)*

DUE TO

18. MEDICAL CERTIFICATION

*Carcinoma of Stomach*INTERVAL BETWEEN
ONSET AND DEATHANTECEDENT CAUSE(S) *(B)*

—

DISEASES OR CONDITIONS, IF ANY, *(B)*
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO*(C)*II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

2D. AUTOPSY?
YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

M. While
at work Not while
at work 22. I hereby certify that I attended the deceased from *2-19-55*, 19 *10.3-19-55*, 19, that I last saw the deceased
alive on *3-18-55*, 19, and that death occurred at *4:45 P.M.* from the causes and on the date stated above.

SIGNATURE

John T. Coker

ADDRESS (Street, city, town, state)

DATE SIGNED *3-2-55*23. BURIAL, CREMATION,
REMOVAL (SPECIFY)*Burial*

DATE THEREOF

3/23/55

NAME OF CEMETERY OR CREMATORI

Lady of SORROWS

LOCATION (City, town, or county)

Errolsville MD

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE *March 23 1955* MR. *Edward Collier* FERNARD HARDY *Errolsville MD*

INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 T0M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02260

2286

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH Anne Arundel COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Crownsville		2. USUAL RESIDENCE (HOME) OF DECEASED MARYLAND STATE Maryland COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore STREET ADDRESS 723 W. Fayette St. ✓ 10 HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital	
3. NAME OF DECEASED (Type or Print) Hattie		4. DATE (Month) (Day) (Year) OF DEATH March 24 1955	
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Unk.
9. AGE last birthday 67? yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.		11. BIRTHPLACE (State or foreign country) Unk.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unk.	
14. MOTHER'S MAIDEN NAME Unk.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no	
16. SOCIAL SECURITY NO. Unk.		17. INFORMANT & ADDRESS Hospital Records	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 443X IMMEDIATE CAUSE (A) Hypostatic Pneumonia		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		Cerebrovascular Accident	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH Diabetes Mellitus		Hypertensive & Arteriosclerotic Cardiovascular D's.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION ----	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21b. PLACE (Home, term, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) ----	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) ---- M. <input type="checkbox"/> work <input type="checkbox"/> Not while at work		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? ----			
22. I hereby certify that I attended the deceased from 6/ 11, 1953, to 3/ 24, 1955, that I last saw the deceased alive on 3/24, 1955, and that death occurred at 8:45 PM, from the causes and on the date stated above. SIGNATURE <i>Stanley C. Sergeant, M.D.</i> DATE SIGNED 3/25/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE PHREROF 3/30/55	
24. REC'D BY REGISTRAR DATE 3/25/55		REGISTRAR'S SIGNATURE Tuckerin D. Price	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		A. H. Holtzman 3918 Oberlin Rd.	

S.A. CUNNINGHAM

DEPARTMENT

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly will be retained for us as a burial permit.

VS 415C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

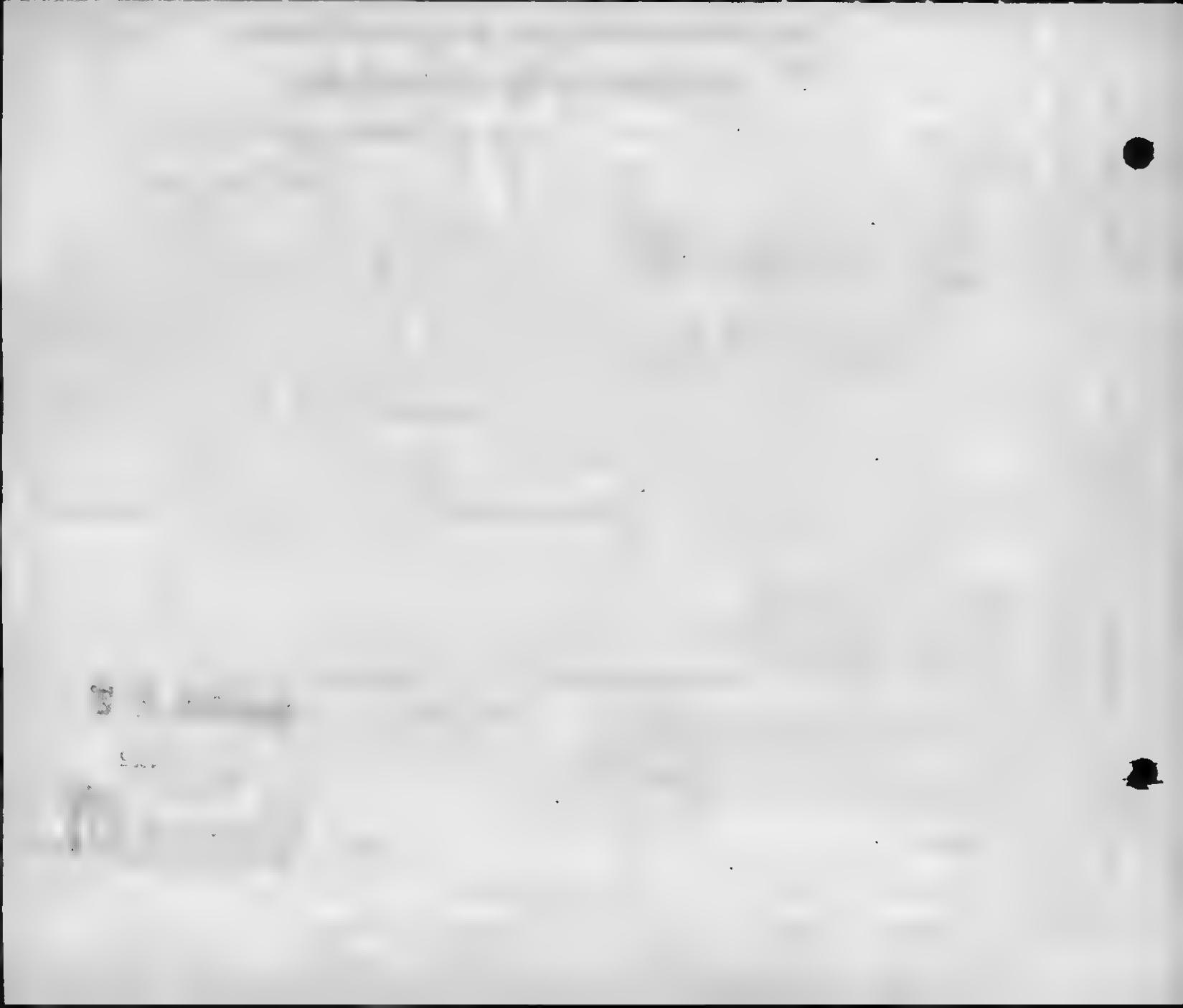
02261

2287

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH COUNTY <u>ANNE ARUNDEL</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>BELHAVEN BEACH</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Lakewood Road</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>Anne Arundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bellhaven Beach</u> STREET ADDRESS <u>Lakewood Road</u>			
3. NAME OF DECEASED (First) <u>JOHN</u> (Middle) <u>K. F.</u> (Last) <u>RESTING</u> (Type or Print)				4. DATE OF DEATH <u>March 16 1955</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W 17 1 TS</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10/26/10</u>	9. AGE last birthday <u>64</u> yrs.	10. IF UNDER 1 YEAR Months <u></u>	11. IF UNDER 24 HRS Days <u></u>	12. Hours <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oil Burner</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Louis Resting</u>		14. MOTHER'S MAIDEN NAME <u>Mary Agnes Bunner</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-03-1150</u>		17. INFORMANT & ADDRESS <u>Mrs. K. F. Resting - 1074 (same)</u>		18. MEDICAL CERTIFICATION <u>Carcinoma Lung</u>	
19. I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>16.2x</u>		IMMEDIATE CAUSE <u>(A)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>			
ANTECEDENT CAUSE(S) <u>Due to</u>		DUE TO <u>(B)</u>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Due to</u>		DUE TO <u>(C)</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) <u>Bellhaven Beach</u> (State) <u>Md.</u>			
21d. TIME OF INJURY (Month) <u>March</u> (Day) <u>15</u> (Year) <u>1955</u> (Hour) M. <u>at work</u> <input type="checkbox"/> Not while <u>at work</u> <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/14</u> , 19 <u>55</u> , to <u>3/16</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/15</u> , 19 <u>55</u> , and that death occurred at <u>8:45 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>J. Brady Smith</u> M.D. ADDRESS (Street, city, town, state) <u>Bellhaven Beach Md.</u> DATE SIGNED <u>3/16/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3/19/55</u>		NAME OF CEMETERY OR CREMATORIAL <u>MEADOW RIDGE</u>		LOCATION (City, town, or county) <u>HOWARD CO.</u> (State) <u>M.D.</u>	
24. REC'D BY REGISTRAR DATE <u>March 17, 1955</u>		REGISTRAR'S SIGNATURE <u>Z. D'Alba</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>R.V. SINGLETSON GREEN BILRNE</u>			



INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02262

2248

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH COUNTY <u>ANNAPURNE</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ANNAPOLIS</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>ANNAPURNE Co.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS <u>40 Southgate Ave.</u> (If rural give location)			
3. NAME OF DECEASED (First) <u>MARGARET</u> (Middle) <u>Dowling</u> (Last) <u>King</u> (Type or Print)				4. DATE OF DEATH (Month) <u>3</u> (Day) <u>27</u> (Year) <u>1955</u>			
5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>Sept. 11, 1875</u>		9. AGE last birthday <u>79</u> yrs. IF UNDER 1 YEAR Months <u>0</u> Deys <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>THOMAS DOWLING</u>				14. MOTHER'S MAIDEN NAME <u>KATHERINE CHRISTOPHER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. 17. INFORMANT & ADDRESS <u>WM F. KING ANNAPOLIS MD</u>			
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>153X</u> IMMEDIATE CAUSE (A) <u>Cancer of Bowel with</u> ANTECEDENT CAUSE(S) DUE TO <u>metastases to liver.</u> DISEASES OR CONDITIONS, IF ANY, (B) <u>giving rise to the above cause</u> STATING UNDERLYING CAUSE LAST. DUE TO <u>due to</u> (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY, street, office bldg., etc.) <u>1030A.M.</u>		21c. WHERE DID INJURY OCCUR? (City or town) <u>ANNAPOLIS</u> (County) <u>MARYLAND</u> (State)			
21d. TIME OF INJURY (Month) <u>3</u> (Day) <u>27</u> (Year) <u>1955</u> (Hour)		21e. INJURY OCCURRED M. <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/27/55</u>, to <u>3/27/19</u>, that I last saw the deceased alive on <u>3/27/55</u>, and that death occurred at <u>10:30A.M.</u> from the causes and on the date stated above SIGNATURE <u>John M. Lybhort & Sons</u> DATE SIGNED <u>3/29/55</u> <u>BURIAL</u> 							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3/20/55</u>		NAME OF CEMETERY OR CREMATORIAL <u>BALDWIN MEMORIAL</u>		LOCATION (City, town, or county) <u>M.L.ERSVILLE MO.</u> (State)	
24. REC'D BY REGISTRAR DATE <u>March 29, 1955</u>				REGISTRAR'S SIGNATURE <u>J. O'Donnell</u> FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lybhort & Sons</u> ADDRESS <u>ANNAPOLIS MD.</u>			



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2249

02263

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <i>Anne Arundel</i> MARYLAND CITY (If outside corporate limits, write RURAL OR enter 1st & 2nd nearest town) TOWN <i>Annapolis</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>MD</i> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baltimore</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>03 EMERGENCY HOSP.</i>		STREET ADDRESS <i>3322 Clark Lane</i>	
3. NAME OF DECEASED (Type or Print) <i>Julius A. Khawans</i>		4. DATE OF DEATH <i>3-18-1955</i>	
S SEX <i>MALE</i>	6. COLOR OR AGE <i>WHITE</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <i>MARRIED</i>	8. DATE OF BIRTH <i>8-9-1896</i>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if <i>MERCHANT</i>)		10b. KIND OF BUSINESS OR INDUSTRY <i>MENS WEAR</i>	9. AGE last birthday <i>58 yrs.</i>
13. FATHER'S NAME <i>DAVID</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, MD</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <i>Mohaye Khawans - SAME</i>		18. MEDICAL CERTIFICATION DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>Myocardial infarction, anterior septal</i>	
IMMEDIATE CAUSE <i>Septal</i>		ANTECEDENT CAUSE(S) <i>due to</i> DISEASES OR CONDITIONS, IF ANY, <i>due to</i> GIVING RISE TO THE ABOVE CAUSE <i>due to</i> STATING UNDERLYING CAUSE LAST. <i>due to</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Congestive Failure</i>		<i>Diabetes Mellitus</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (F EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, term, factory, of INJURY <i>street, office bldg., etc.</i>)	
21d. TIME OF INJURY (Month) <i>March</i> (Day) <i>18</i> (Year) <i>1955</i> (Hour) <i>10</i>		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>3/14 1955</i> to <i>3/18 1955</i> , that I last saw the deceased alive on <i>3/18 1955</i> , and that death occurred at <i>10 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Franklin Shufly</i>		ADDRESS (Street, city, town, state) <i>Annapolis, Md.</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>3-20-55</i> NAME OF CEMETERY OR CREMATORIUM <i>Beth Tfiloh</i> LOCATION (City, town, or county) <i>Baltimore, Md.</i>	
24. REC'D BY REGISTRAR DATE <i>March 22, 1955</i>		REGISTRAR'S SIGNATURE <i>Frank J. Francis</i> FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis Inc 2100 Eutaw Pl</i>	

30 May

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**02264****2288****CERTIFICATE OF DEATH**Reg. Dist. No. **24****1. PLACE OF DEATH**

COUNTY	ANNE ARUNDEL	MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	
X TOWN	GLEN BURNIE	11 YEARS
HOSPITAL OR INSTITUTION OR STREET ADDRESS	201 THIRD AVE., S.W.	

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE	MARYLAND	COUNTY	ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN	GLEN BURNIE		X
STREET ADDRESS	201 THIRD AVE., S.W.		1

**3. NAME OF
DECEASED**
(First) (Middle) (Last)

Martha — Kriewald

4. DATE (Month) (Day) (Year)

5. SEX 6. COLOR OR
RACE7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired) **HOUSE WORK**10b. KIND OF BUSINESS
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

13. FATHER'S NAME

FREDERICK DEICHGRABER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT & ADDRESS

No

None

MRS. ALMA FERNER

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

42. IMMEDIATE CAUSE

(A) **Coronary thrombosis**

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST, DUE TO

(C)

Arterio sclerosis & HypertensionINTERVAL BETWEEN
ONSET AND DEATH

3 weeks

?

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

M. While at work Not while at work

21e. INJURY OCCURRED

M. at work at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **det**, 1954, to **March**, 1955, that I last saw the deceased alive on **2-26**, 1955, and that death occurred at **7:00 AM**, from the causes and on the date stated above.

SIGNATURE

Ed McDonald

ADDRESS (Street, city, town, state)

DATE SIGNED

3-3-5523. BURIAL, CREMATION,
REMOVAL (SPECIFY)**BURIAL**DATE **March 5, 1955**

DATE THEREOF

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county)

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

DATE **March 5, 1955**

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

(State)

26. DEATH CERTIFICATE

ADDRESS

(State)

Sherry
10

2250 MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

02265

Reg. Dist. No. 242

1. PLACE OF DEATH COUNTY <i>A.A.C.O.</i>			2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Md.</i>		
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>BETHESDA, MD.</i>		
LENGTH OF STAY (In this place)			STREET ADDRESS <i>BRADLEY BLUFF RIVER RD.</i>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			(If rural give location)		
3. NAME OF DECEASED (Type or Print) <i>Albert EDWARD Landvoigt</i>			4. DATE OF DEATH <i>3 26 1955</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>JAN 11, 1892</i>	9. AGE last birthday yrs. <i>63</i>	10. If under 1 year Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Milkman (buses)</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>BANKING</i>		
11. BIRTHPLACE (State or foreign country) <i>D.C.</i>			12. CITIZEN OF WHAT COUNTRY <i>USA</i>		
13. FATHER'S NAME <i>EDWARD LANDVOIGT</i>			14. MOTHER'S MAIDEN NAME <i>VERGIA ANN WHEELOCK</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>			16. SOCIAL SECURITY NO. <i>601</i>		
17. INFORMANT			18. MEDICAL CERTIFICATION		

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) *Cardiac disease*

INTERVAL BETWEEN
ONSET AND DEATH

udden

Antecedent cause(s)

Disease or conditions, if any, (b)
giving rise to the above cause
stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	PLACE OF INJURY	Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year)	INJURY OF INJURY	WHEN IT m. WORK	NOT WHILE at work	HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined .

SIGNATURE

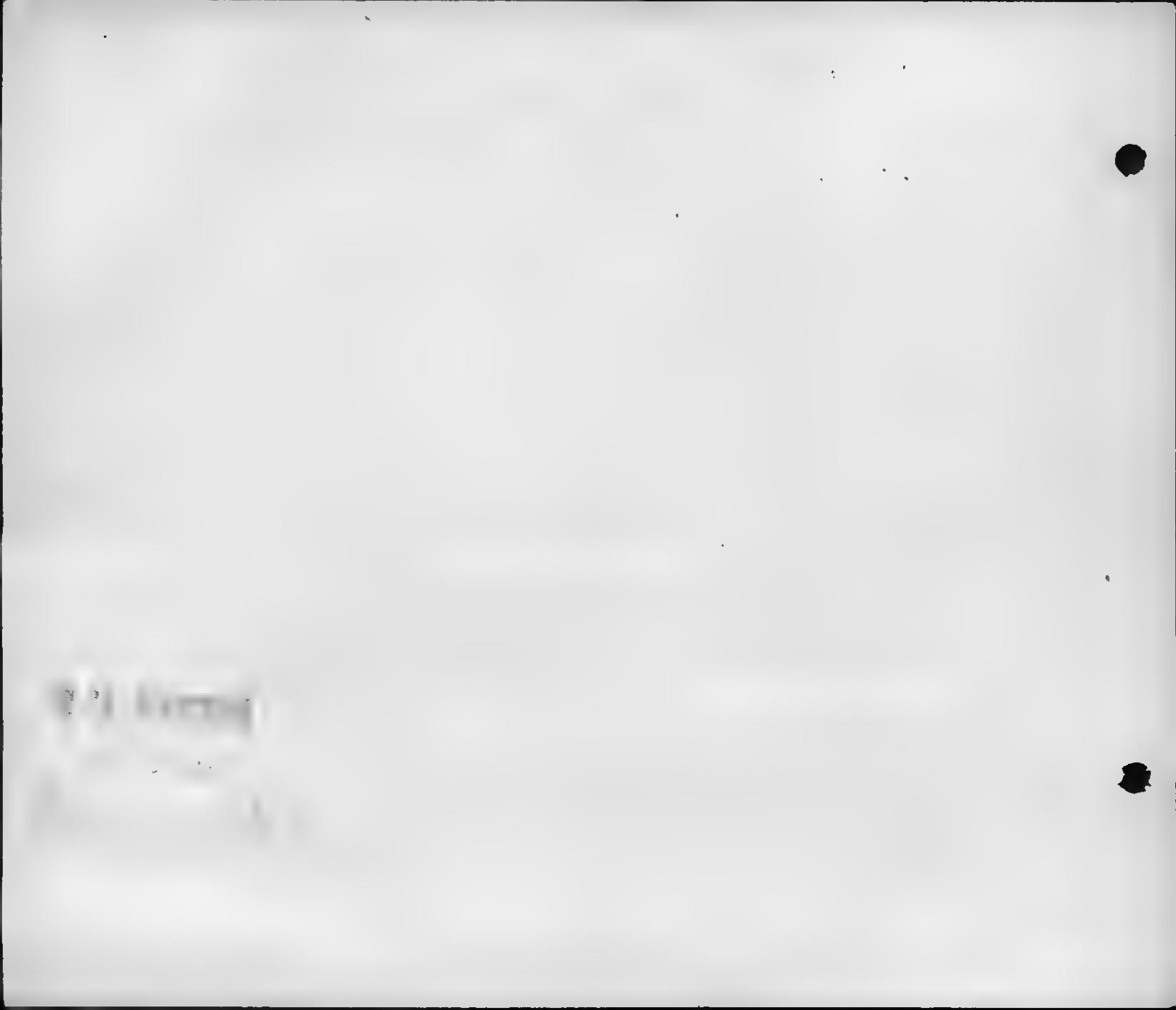
(Degree or title)

ADDRESS

DATE SIGNED

3/26/55.

23. BURIAL, CREMATION REMOVAL (Specify) <i>BURIAL</i>	DATE THEREON <i>3-29-1955</i>	NAME OF CEMETERY OR CREMATORIAL ESTABLISHMENT <i>ARLINGTON NATIONAL</i>	LOCATION (City, town, or county) <i>ARLINGTON, VA.</i>	(State)
DATE REC'D BY LOCAL REG. <i>Mar. 28, 55</i>	REG. <i>Carrie J. Campbell</i>	REG. <i>Carrie J. Campbell</i>	FUNERAL DIRECTOR <i>W. Lee Jones</i>	ADDRESS <i>300 45th St. N.E. WASH. D.C.</i>



MARGIN RESERVED FOR BIRMINGHAM

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2289 MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

02266

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <i>Al. W. DeMarest.</i>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>MARYLAND</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>TOWN 98-DeMarest</i>		LENGTH OF STAY (In this place) <i>30 years.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Seew Seafire.</i>		STREET ADDRESS <i>Seew Seafire.</i>	
3. NAME OF DECEASED (Type or Print) <i>is. Lemieux</i>	(First) <i>is.</i>	(Middle) <i>Le</i>	(Last) <i>Lemieux</i>
4. DATE OF DEATH <i>1955</i>	(Month) <i>Aug.</i>	(Day) <i>4</i>	(Year) <i>1955</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>9/17/93</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Preparing legal meals.</i>	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>61</i> yr.	11. BIRTHPLACE (State or foreign country) <i>France, U.S.A.</i>
12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	13. FATHER'S NAME		
14. MOTHER'S MAIDEN NAME <i>?</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	
16. SOCIAL SECURITY NO. <i>212-36-0841</i>		17. INFORMANT AND ADDRESS <i>Records found in his home.</i>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

42-1
Immediate cause

(a) *Ischaemic Colitis*

INTERVAL BETWEEN
ONSET AND DEATH

Antecedent cause(s)

Diseases or conditions, if any, (b)
giving rise to the above cause
stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY

Yes No

21. INTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input checked="" type="checkbox"/>	PLACE (Home, farm, factory, street, of office bldg., etc.) <i>INJURY</i>	(CITY OR TOWN) <i>(CITY OR TOWN)</i>	(COUNTY) <i>(COUNTY)</i>	(STATE) <i>(STATE)</i>
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>TIME (Month) (Day) (Year) (Hour) OF INJURY</i>	INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy, Inspection Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes accident suicide homicide undetermined

SIGNATURE *Seew Seafire, W.* (Degree or title) *Seew Seafire, W.* ADDRESS DATE SIGNED *3-10-55*

DATE OF Cremation	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county) <i>(City, town, or county)</i>	(State) <i>(State)</i>
BURIAL (If applicable) <i>BURIAL MARCH 11, 1955</i>		BALTIMORE NATIONAL		MARYLAND
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE R.I.C. <i>3-10-55</i>		24. FUNERAL DIRECTOR ADDRESS BALTIMORE, MARYLAND		



INSTRUCTIONS

I

THE ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2251

02267

CERTIFICATE OF DEATH

Item 7, FilmG179 3-23-55 et

Reg. Dist. No. 21

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY [If outside corporate limits, write RURAL OR and give nearest town] TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY [If outside corporate limits, write RURAL and give nearest town] OR TOWN	COUNTY AA.
Anne Arundel Baltimore	4 mos.	Maryland	AA.
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS [If rural give location] 1312 West St., Baltimore Md.		
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) JAMES C (Middle) (Last) LEWIS		(Month) (Day) (Year) March 6 1955	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Jan. 8, 1875
9. AGE last birthday yrs. 80	10. KIND OF BUSINESS OR INDUSTRY Care Taker London Park Cemetery Frederick Co., Md.	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Alfred Lewis	14. MOTHER'S MAIDEN NAME Annabelle Winter		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. 216-07-7266	17. INFORMANT & ADDRESS Mildred S. Cordeley Batt. St.	2237 1/
18. MEDICAL CERTIFICATION IMMEDIATE CAUSE (A) Atherosclerotic Cardio Vascular ANTECEDENT CAUSE(S) DUE TO (B) Arterial with claudication DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
INTERVAL BETWEEN ONSET AND DEATH Yrs -			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		19. DATE OF OPERATION	
19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED M. While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3/4 1955, to 3/16 1955, that I last saw the deceased alive on 3/4 1955, and that death occurred at 9 P.M., from the causes and on the date stated above. SIGNATURE M. D. ADDRESS (Street, city, town, state) Mannid R. Evans, M.D. Frederick Co., Md.			
DATE SIGNED 3/8/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3-10-55	NAME OF CEMETERY OR CREMATORIAL Kempstown
24. REC'D BY REGISTRAR DATE 3/14/55		REGISTRAR'S SIGNATURE Tom. J. French	LOCATION (City, town, or county) Frederick Co., Md.
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			

PIPEREAU V. S.

1975



CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Earligh Heights</u> <u>Severna Park</u>		OR TOWN <u>Earligh Heights</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>Brook 449 Severna Park</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED WIDOWED, DIVORCED (Specify) <u>Married</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, if unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hond</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p><u>420</u> Immediate cause (a) ... <u>Myocardial infarction</u> (b) ... <u>Hypertension</u> (c) ... <u>Cardio-vascular disease</u> Years</p> <p>Antecedent cause(s) <u>Years</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ... <u>Years</u></p> <p>(c) ... <u>Years</u></p>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
<p>22. I hereby certify that I attended the deceased from <u>have never attended the deceased</u>, 19<u>10</u>, to <u>19</u>, that I last saw the deceased</p> <p>alive on <u>19</u>, and that death occurred at <u>10</u> P.m., from the causes and on the date stated above.</p> <p>SIGNATURE <u>Robert R. Hales M.D.</u> ADDRESS <u>Severna Park Md 20703</u> DATE SIGNED <u>March 16 1955</u></p>			
23. BURIAL, CREMATION REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG		24. FUNERAL DIRECTOR ADDRESS <u>Glen Burnie, Md.</u>	
REG <u>March 18 1955</u>		REGISTRATION'S SIGNATURE <u>L. J. D'Alba</u>	

1955

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be attached for us as a burial transit permit.

VS AISC 155 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02269

2291

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN TOWN	Anne Arundel Crownsville	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	MARYLAND 3 mos. 19 days Baltimore City
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) DEATH 3	
(First) Charles H. Lowery		(Day) 1 1955	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 1877?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (State or foreign country) Maryland		9. AGE last birthday 78? yrs. 3 months	
13. FATHER'S NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U. S.	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk.	
16. SOCIAL SECURITY NO. Unk.		17. INFORMANT & ADDRESS Hospital Records	
18. MEDICAL CERTIFICATION 450.0 IMMEDIATE CAUSE (A) Generalized Arteriosclerosis ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, ■ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH Known to us since 11/10/54	
19a. DATE OF OPERATION - - -		19b. MAJOR FINDINGS OF OPERATION - - -	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) - - -	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) - - - M.		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) - - -	
21f. HOW DID INJURY OCCUR? - - -		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22. I hereby certify that I attended the deceased from 11/10 1954 to 3/1 1955, that I last saw the deceased alive on 3/1 1955, and that death occurred at 3:45 P.M. from the causes and on the date stated above. SIGNATURE <i>W. J. Schreder, Jr.</i> ADDRESS (Street, city, town, state) DATE SIGNED M. D. Crownsville, Md. 3/1/55			
23. BURIAL, Cremation, REINTERMENT (Specify) Burial		DATE THEREOF 3/1/55	NAME OF CEMETERY OR CREMATORIAL Mt. Auburn
24. REC'D BY REGISTRAR DATE Mar. 7, 1955		REGISTRAR'S SIGNATURE <i>Katherine M. Joyce</i>	LOCATION (City, town, or county) Baltimore City
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 322 N. <i>Mrs. Katie R. Williams Schreder, Jr.</i>			

BUKEAU V. S.

125

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE. 18

02270

Reg. Dist. No. 1

ONE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information, carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY		Anne Arundel MARYLAND		STATE Md. COUNTY a a	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN Annapolis Md.				TOWN Annapolis	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural give location)		
3. NAME OF DECEASED: (Type or Print)			4. DATE (Month) (Day) (Year)		
James Mitchell Magruder			3 - 11 - 1955		
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED WIDOWED, DIVORCED. (Specify)	
8. DATE OF BIRTH: 8-4-1865		9. AGE last birthday: 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life. (If retired)			10B. KIND OF BUSINESS OR INDUSTRY: Minister		
11. BIRTHPLACE (State or foreign country): Mississippi			12. CITIZEN OF WHAT COUNTRY: U.S.A.		
13. FATHER'S NAME: William Howard Magruder			14. MOTHER'S MAIDEN NAME: Ann E. Mitchell		
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, No, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. -		
17. INFORMANT & ADDRESS: Margaret M. Magruder			18. MEDICAL CERTIFICATION		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 452X IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			(A) Gangrene (dry) right foot DUE TO Thrombosis of aneurysm of rt. (B) DUE TO Septic tailoring + other arteriosclerosis, generalized		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			INTERVAL BETWEEN ONSET AND DEATH 4 wk.		
19A. DATE OF OPERATION: 0 -		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from ..., 1950, to 31/1/1955, that I last saw the deceased alive on 31/1/1955, and that death occurred at 3:57 PM, from the causes and on the date stated above. SIGNATURE ADDRESS DATE SIGNED Frank M. Shephy M.D. Annapolis 3/1/55					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3-11-55		NAME OF CEMETERY OR CREMATORIUM Cedar Cliff Crem. Cem't	
DATE REC'D BY LOCAL REGISTRAR March 11, 1955		REGISTRAR'S SIGNATURE O. French		LOCATION (City, town, or county) Annapolis Md.	
24. FUNERAL DIRECTOR John M. Taylor Sons Annapolis Md.		ADDRESS			

10 26 0

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2292

02271

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH

COUNTY Anne Arundel

CITY (If outside corporate limits, write RURAL
OR and give nearest town)

TOWN Fort George G. Meade

MARYLAND

LENGTH OF STAY
(in this place)

2 months

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Illinois *MD*

COUNTY Kankakee

CITY (If outside corporate limits, write RURAL and give nearest town)

OR
TOWN Buckingham

(If rural give location)

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

50 U.S. Army Hospital

3. NAME OF
DECEASED
(Type or Print)

(First)

(Middle)

(Last)

Connie

Ann

McClintock

4. DATE (Month)
OF
DEATH

March 13 1955

IF UNDER 1 YEAR
Months Days Hours Min.

5. SEX

6. COLOR OR
RACE7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

8. DATE OF BIRTH

9. AGE last birthday

10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

none

10b. KIND OF BUSINESS
OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT
COUNTRY?

USA

13. FATHER'S NAME

Charles Edward McClintock

14. MOTHER'S MAIDEN NAME

Martha Virginia Pfutzenrueter

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.)

(If Yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

111-11-1111

17. INFORMANT & ADDRESS

Father:

89th AAA, Ft. GG Meade, Md.

INTERVAL BETWEEN
ONSET AND DEATH

3 hrs 10 min

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

775X

IMMEDIATE CAUSE

(A)

Prematurity - 20 weeks gestation

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST, DUE TO

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20 AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

M. While at work Not while at work at work

22. I hereby certify that I attended the deceased from 1845 13 Mar 55, to 2155 13 Mar 55, that I last saw the deceased alive on 13 Mar 55, and that death occurred at 2155 M, from the causes and on the date stated above.

ADDRESS (Street, city, town, state)

DATE SIGNED

FREDERICK S. EADIE, CAPT., MC M.D.

Fort George G. Meade, Md. 13 Mar 55

(State)

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county)

(State)

Removal - permission granted to remove remains to Second Army Med Lab, FGGM, Md.

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE 14 Mar 55

ARTHUR J. GOMBOSH, CAPT., MSC

none

2035272180

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

SHIRTAU V. S

MAR 16 1955

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2293

CERTIFICATE OF DEATH

02272

Reg. Dist. No. 28

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town)	Anne Arundel	MARYLAND	STATE CITY (If outside corporate limits, write RURAL and give nearest town)	Maryland	COUNTY Caroline
TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS	Crownsville	LENGTH OF STAY (In this place)	TOWN STREET ADDRESS	Preston	(If rural give location)
2 yrs. 2 mos. 24 days			Rt. #2, Box 87B		
3. NAME OF DECEASED (First) Wilbert (Middle) Monroe (Last) Murray			4. DATE OF DEATH (Month) (Day) (Year) 3 7 1955		
5. SEX Male		6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 10/23/01	9. AGE last birthday 53 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Unemployed	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME William H. Murray			14. MOTHER'S MAIDEN NAME Clara E. Hubbard		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS Hospital Records	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 0256 IMMEDIATE CAUSE (A) Terminal bronchopneumonia ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) General Paresis II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
18e. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY Street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 12/11 1952, to 3/7 1955, that I last saw the deceased alive on 3/7 1955, and that death occurred at 4:30 P.M., from the causes and on the date stated above.					
SIGNATURE <i>L. Benedict</i> M.D. (L. Benedict) Crownsville, Md. DATE SIGNED 3/8/55					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF 3/12/55	NAME OF CEMETERY OR CREMATORIUM Donestown Cemetery	LOCATION (City, town, or county) Donestown Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE K. M. 5/26	25. FUNERAL DIRECTOR'S SIGNATURE J. J. Thompson & Son - Federalsburg Md.		
DATE 3-12-55					ADDRESS

ESTATE OF

1955

1955

MARYLAND STATE DEPARTMENT OF HEALTH

02273

2253

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md</u> COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Annapolis</u>		TOWN <u>Annapolis</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>903 Jackson</u>		STREET ADDRESS <u>903 Jackson</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Carl</u>	(Middle) <u>Wayne</u>	(Last) <u>Neumiller</u>
4. SEX <u>Male</u>	5. COLOR OR RACE <u>White</u>	6. MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	7. DATE OF BIRTH <u>1-17-53</u>
8. AGE last birthday 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	9. KIND OF BUSINESS OR INDUSTRY <u>—</u>	10b. AGE last birthday 11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md</u>	10c. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
12. FATHER'S NAME <u>Elmer L. Neumiller</u>	13. MOTHER'S MARRIED NAME <u>Ruby L. Sears</u>	14. INFORMANT AND ADDRESS <u>Elmer L. Neumiller</u> (2)	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>
16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT AND ADDRESS <u>Elmer L. Neumiller</u> (2)	18. MEDICAL CERTIFICATION	
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>916.0</u> Immediate cause <u>Asphyxie</u> Antecedent cause(s) <u>3rd degree burns - 100% body surface</u> Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last <u>Sudden</u>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> OF CAUSE OF DEATH. <u>House fire</u>		PLACE (Home, farm, factory, street, of office bldg., etc.) <u>Home</u>	(CITY OR TOWN) <u>Anne Arundel</u> (COUNTY) <u>AA Co</u> (STATE) <u>Md</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3 29 55 A.m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>House fire</u>	
22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> SIGNATURE <u>Elmer L. Neumiller</u> (Degree or title) <u>MD</u> ADDRESS <u>903 Jackson</u> DATE SIGNED <u>3/31/55</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>3/31/55</u>	DATE THEREOF <u>3/31/55</u>	NAME OF CEMETERY OR CREMATORIAL <u>Holcroft Memorial</u>	LOCATION (City, town, or county) <u>Anne Arundel, Md</u> (State) <u>Md</u>
DATE REC'D BY LOCAL REG. <u>March 30, 1955</u>	REG. <u>John M. Taylor</u>	REG. <u>John M. Taylor</u>	REG. <u>Sus Annapolis, Md.</u>
REG. <u>John M. Taylor</u>		REG. <u>Sus Annapolis, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUHLAU V. S

APR 1 1968

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2294

CERTIFICATE OF DEATH

02274

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY Tracy's Landing (If rural give location)
Anne Arundel Tracy's Landing	MARYLAND	Md.	Anne Arundel Tracy's Landing
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	Mc. Kenzie 214
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
Maggie Virginia Owens		(Month)	(Day)
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Female	colored	MARRIED Oct. 25, 1854	9. AGE last birthday 71 yr.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
John Carroll		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420. I IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		coronary artery disease with chronic myocardial failure	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OP INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov.</u> , 1953, to <u>March 18, 1953</u> , that I last saw the deceased alive on <u>March 18, 1953</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Emily A. Wilson</u>		ADDRESS (Street, city, town, state) <u>Lothian, Md.</u> DATE SIGNED <u>3-14-53</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar. 13, 1953</u> NAME OF CEMETERY OR CREMATORIUM <u>Adams</u> LOCATION (City, town, or county) <u>Lothian, Md.</u> (State)	
24. REC'D BY REGISTRAR DATE <u>3-22-53</u>		REGISTRAR'S SIGNATURE <u>Emily A. Wilson</u> 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. S. Johnson, Annapolis, Md.</u>	

MR

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02275

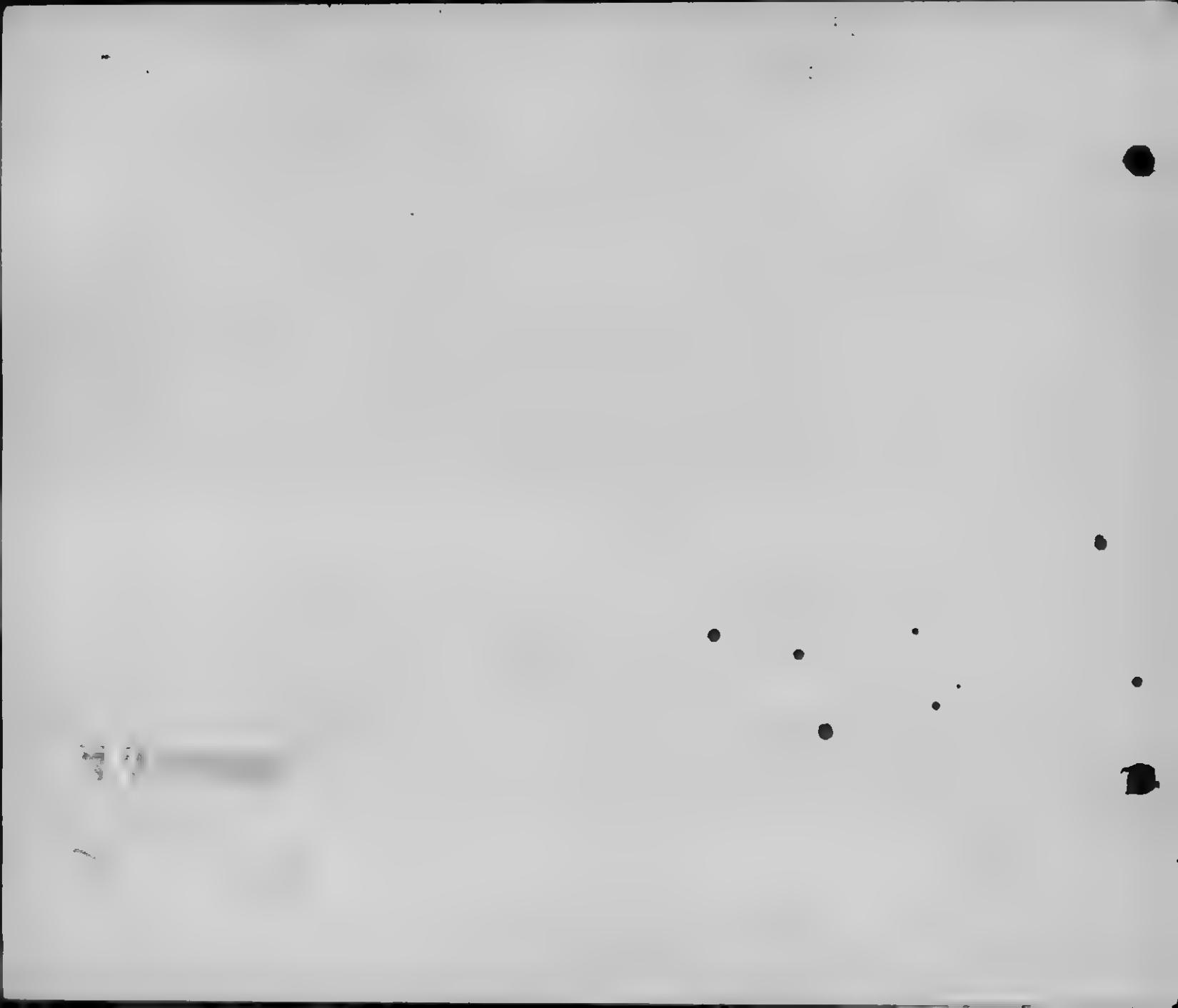
2295 MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 24

1. PLACE OF DEATH CITY TOWN		2. USUAL RESIDENCE (HOME) OF DECEASED STATE CITY TOWN STREET ADDRESS	
Annapolis P.O. Pasadena		MARYLAND Length of Stay (In this place) 6 months	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Box 87 - Route 1		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN STREET (If rural, give location)	
3. NAME OF DECEASED (First) (Type or Print) Harry		4. DATE OF DEATH March 3 (Month) (Year) 1955	
5. SEX M.		6. COLOR OR RACE W.	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed.		8. DATE OF BIRTH 9. AGE last birthday 79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during time of working life, even if retired) Retired Funeral Director		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Harry C. Patterson		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 210-10-7104	
17. INFORMANT AND ADDRESS Mr. L. D. Patterson (Son)		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause Hypertension Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (a) (b) (c) General arteriosclerotic disease Sudden			
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. INTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		22. PLAC. (Home, farm, factory, street, of office bldg., etc.) INJURY	
TIME (Month) INJURY	(Day) m.	(Year) work	(Hour) Not while at work
INJURY OCCURRED How did injury occur?			
23. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that it said deceased died on the day stated above, and death in my opinion resulted from: natural causes, accident, suicide, homicide, undetermined.			
SIGNATURE Lester H. Patterson		(Degree or title) Medical Examiner	DATE SIGNED 3/3/55
24. Cremation (If Yes, specify) Yes		NAME OF CEMETERY OR CREMATORIAL London Park	
DATE REC'D BY LOCAL REG. REC.		LOCATION (City, town, or county) Baltimore	
REG		24. FUNERAL DIRECTOR Howard de Ward 4107 Wrenbury	
March 10, 1955		ADDRESS	
L. J. St. Alba			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.



TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2296

CERTIFICATE OF DEATH

02276

Reg. Dist. No. 8

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY OR TOWN	ANNE ARUNDEL ODENTON	MARYLAND LENGTH OF STAY (In this place)	STATE MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ODENTON
HOSPITAL OR INSTITUTION OR STREET ADDRESS	00	STREET ADDRESS	(If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) MARION (Middle) I (Last) POORE		MARCH 31, 1955	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH January 7, 1876
9. AGE last birthday 79 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife	11. KIND OF BUSINESS OR INDUSTRY own home	12. BIRTHPLACE (State or foreign country) Washington, D.C.
13. FATHER'S NAME John Campbell	14. MOTHER'S MAIDEN NAME Unknown	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. James S. Poore- Son- same as # 2	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 4. IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 16 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. et work <input type="checkbox"/> Not while el work <input type="checkbox"/>	
21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> el work <input type="checkbox"/>			
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March</u> , 1955, to <u>March 31</u> , 1955, that I last saw the deceased alive on <u>March 29</u> , 1955, and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Edward J. Poore</u> ADDRESS (Street, city, town, state) <u>6 Lombard St. 17th</u> DATE SIGNED <u>3-31-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF April 4, 55	NAME OF CEMETERY OR CREMATORIAL Our Lady of the Fields	LOCATION (City, town, or county) Millersville, A.A. Maryland
24. REC'D BY REGISTRAR DATE 4-3-55	REGISTRAR'S SIGNATURE K M Tye	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HOPPING FUNERAL HOME ANNAPOLIS, MD. Ben Hopping	

S. A. 117-20

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 415C 1-55 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02277

2297

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>HANNE ARUNDEL</u> CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>ODENTON RURAL</u>		MARYLAND LENGTH OF STAY (in this place) <u>36 YRS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WAUGH CHAPEL ROAD</u>		STATE <u>MARYLAND</u> COUNTY <u>HANNE ARUNDEL</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ODENTON (RURAL)</u> STREET ADDRESS <u>WAUGH CHAPEL ROAD</u>	
3. NAME OF DECEASED (First) <u>WILLIAM</u> (Middle) (Type or Print)		(Last) <u>PULLMAN</u> 4. DATE OF DEATH <u>MARCH. 15</u> 1955	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>SEPT. 6 1876</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	9. AGE last birthday <u>78</u> yrs. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
13. FATHER'S NAME <u>FREDERICK</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS <u>HELENA K. PULLMAN</u>		18. MEDICAL CERTIFICATION <u>Acute Coronary Thrombosis</u> <u>Generalized arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 years</u>	
II DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1 IMMEDIATE CAUSE</u> ANTECEDENT CAUSE(S) <u>None</u> DUE TO <u>(A)</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE <u>None</u> DUE TO <u>(B)</u> STATING UNDERLYING CAUSE LAST <u>None</u> DUE TO <u>(C)</u>		19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE-OF-DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, street, office bldg., etc.) <u>None</u>	
21d. TIME OF INJURY (Month) <u>March</u> (Day) <u>15</u> (Year) <u>1955</u> (Hour) <u>None</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 15, 1955</u> to <u>March 15, 1955</u> , that I last saw the deceased alive on <u>March 13, 1955</u> , and that death occurred at <u>None</u> M. from the causes and on the date stated above.			
SIGNATURE <u>Joseph L. Parker</u>		ADDRESS <u>1010 E. 36th St. Baltimore 17, MD</u> DATE SIGNED <u>March 17, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIES) <u>BURIAL</u>		DATE THEREOF <u>3/18/55</u> NAME OF CEMETERY OR CREMATORIUM <u>WAUGH CHAPEL</u> LOCATION (City, town, or county) <u>WAUGH CHAPEL MD</u> (State)	
24. REC'D BY REGISTRAR <u>Clare Buckley</u>		REGISTRAR'S SIGNATURE <u>Clare Buckley</u> DATE <u>March 19, 1955</u> 280 alc	
DATE <u>March 19, 1955</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John Dugington</u> ADDRESS <u>Glenview 744</u>	

BUNNELL

175

MARYLAND

2298

12278

STATE DEPARTMENT OF HEALTH

Reg. Dist. No. 24

CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <i>MD</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>RURAL and give nearest town</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>EARLIGH Heights</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Gov. Ritchie Hwy.</i>		STREET ADDRESS <i>Gov. Ritchie Hwy</i>	
3. NAME OF DECEASED (Type or Print) <i>JAMES Stewart</i>	(First) <i>M.</i>	(Middle) <i>W.</i>	(Last) <i>Rennie</i>
4. SEX <i>M.</i>	5. COLOR OR RACE <i>W.</i>	6. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>Married</i>	7. DATE OF BIRTH <i>MAY 18, 1890</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Enginner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>State of Md.</i>	8. DATE OF BIRTH <i>MAY 18, 1890</i>
11. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	9. AGE last birthday <i>64 yrs.</i>
13. FATHER'S NAME <i>JAMES. Rennie</i>		14. MOTHER'S MAIDEN NAME <i>ISABELLA Redman</i>	10. INFORMANT AND ADDRESS <i>Wife</i>
11. BIRTHPLACE (State or foreign country) <i>MD</i>			
12. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>420.1</i> Immediate cause (a) ... <i>Heart Failure</i> <i>myocardial inf</i> 7-8 yrs Antecedent cause(s) <i>Arteriosclerotic C. V. Disease</i> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ... <i>Probable Coronary Insufficiency</i> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <i>Arteriosclerotic C. V. Disease</i>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <i>Patient was not seen alive by me.</i>	
22. I hereby certify that I attended the deceased from ..., 19 ..., to ..., 19 ..., that I last saw the deceased alive on ..., 19 ..., and that death occurred at 0900 m, from the causes and on the date stated above. SIGNATURE <i>Robert P. Hohn</i> ADDRESS <i>Severna Park</i> DATE SIGNED <i>1955</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE <i>April 2, 1955</i>	NAME OF CEMETERY OR CREMATORIAL <i>London Park</i>	LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>
DATE REC'D BY LOCAL REG. <i>April 2, 1955</i>	REG. <i>L. J. D'Alba</i>	24. FUNERAL DIRECTOR <i>T. Washington</i>	ADDRESS <i>Her Burns, Md.</i>



2299

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

02279

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY <u>Glen Burnie - A.A.C.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Same</u> COUNTY <u>-</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Glen Burnie</u> LENGTH OF STAY (In, this place) <u>1/4 year</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Same</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>308 Central Ave. N.W.</u>		STREET ADDRESS <u>Same</u> (If rural, give location) <u>X</u>	
3. NAME OF DECEASED (Type or Print) <u>Elija - M. Rogers.</u>	(First) <u>Elija</u> (Middle) <u>M.</u> (Last)	4. DATE OF DEATH <u>March 8</u>	(Month) <u>March</u> (Day) <u>8</u> (Year) <u>1955</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, (WIDOWED) <u>Widowed</u>	8. DATE OF BIRTH <u>6/15/1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	9. AGE last birthday 87 yrs.
13. FATHER'S NAME <u>John McFadden</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		12. CITIZEN OF WHAT COUNTRY <u>A.S.A.</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Dorothy Dunkle - (Daughter)</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<u>17. X</u> Immediate cause <u>Caecinoma of the Vagina & of the Cervix.</u> (a) <u>8 month.</u> Antecedent cause(s) <u>Caecinoma of the Breast</u> (b) <u>10 year.</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last <u>—</u> (c) <u>—</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Non.</u>			
19a. DATE OF OPERATION <u>1945</u>	19b. MAJOR FINDINGS OF OPERATION <u>Caecinoma of the Breast.</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> OF CAUSE OF DEATH. <u>INJURY</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>—</u> (CITY OR TOWN) <u>—</u> (COUNTY) <u>—</u> (STATE) <u>—</u>		
TIME (Month) <u>—</u> (Day) <u>—</u> (Year) <u>—</u> (Hour) <u>—</u> OF INJURY <u>—</u> m. <u>—</u>	INJURY OCCURRED While at <u>—</u> Not while <u>—</u> work <input type="checkbox"/> at work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u>—</u>
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> SIGNATURE <u>James S. Billingsley M.D.</u> (Degree or title) <u>ADDRESS</u> <u>108 Central Ave. Glen Burnie Md</u> DATE SIGNED <u>March 8, 1955</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/10/55</u>	NAME OF CEMETERY OR CREMATORIAL <u>Woodlawn Cemetery</u>	LOCATION (City, town, or county) <u>Woodlawn</u> (State) <u>Maryland</u>
DATE REC'D BY LOCAL REG. <u>3/9/55</u>	REGISTRAR'S SIGNATURE <u>R.W. French Jr.</u>	24. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook, Inc., 1212 St. Paul St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY; WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10A

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2300

CERTIFICATE OF DEATH

02280

28

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Anne Arundel		STATE Maryland		COUNTY Montgomery			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Crownsville				TOWN Gaithersburg			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS				(If rural give location)	
Crownsville State Hospital		Wallfield Road					
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) DEATH 3 13 55			
John		Thomas		Ross			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS
Male	Negro		1860?	85?	Months	Days	Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				11. BIRTHPLACE (State or foreign country) Maryland			
10b. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <input checked="" type="checkbox"/> (If Yes, give war or dates of service) Unk.				16. SOCIAL SECURITY NO. Unk.			
17. INFORMANT & ADDRESS Hospital Records				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 42. IMMEDIATE CAUSE (A) Myocardial Insufficiency ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, ■ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arteriosclerotic Heart Disease Generalized Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 3 days Known to us since 1/19/55			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1/19, 1955, to 3/13, 1955, that I last saw the deceased alive on 3/13, 1955, and that death occurred at 4 P.M., from the causes and on the date stated above. SIGNATURE <i>Widdegarde Heard Reissman</i> ADDRESS (Street, city, town, state) Crownsville, Md. DATE SIGNED 3/24/55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Buried		DATE THEREOF 3/18/55		NAME OF CEMETERY OR CREMATORIUM Brookmore		LOCATION (City, town, or county) Laytonville, Maryland (State)	
24. REC'D BY REGISTRAR DATE 3-14-55		REGISTRAR'S SIGNATURE K. M. Joyce		25. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville, Md.	

July 20, 1945
Dear Mr. & Mrs. A. E.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02281

2254

CERTIFICATE OF DEATH

Reg. Dist. No. 21

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 4-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS	Anne Arundel Maryland 10 Annapolis	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS	Md. AA Severn (Rural)
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last)		(Month) (Day) (Year)	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH February 21, 1955
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 11. BIRTHPLACE (State or foreign country) Md.
13. FATHER'S NAME John Royal		14. MOTHER'S MARRIED NAME Shirley Mae Wheeler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none	17. INFORMANT & ADDRESS John Royal, Severn, Md.
I DISEASE OR CONDITIONS DIRECTLY LEADING TO DEATH 451X IMMEDIATE CAUSE (A) Spina Bi Fida		18. MEDICAL CERTIFICATION ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	M. at work	21e. INJURY OCCURRED While Not while at work	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 2/21/55 to 3/6/55, 1955, that I last saw the deceased alive on Mar. 5, 1955, and that death occurred at 10:15 A.M. from the causes and on the date stated above. SIGNATURE Howard G. Bennett DATE SIGNED 3-6-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 3/8/55	NAME OF CEMETERY OR CREMATORIUM Glen Haven	LOCATION (City, town, or county) Glen Burnie, Md. (State)
24. REC'D BY REGISTRAR DATE March 8, 1955	REGISTRAR'S SIGNATURE Howard G. Bennett	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hopping and Kirkley, Glen Burnie, Md.	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2255 Item 24 File # 180 4-11-55 et

02282

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH

COUNTY Anne Arundel

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)LENGTH OF STAY
(In this place)

TOWN Annapolis

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

08 Weems Creek

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland

COUNTY Anne Arundel

CITY (If outside corporate limits, write RURAL and give nearest town)

OR
TOWN AnnapolisSTREET
ADDRESS

(If rural give location)

Weems Creek

3. NAME OF
DECEASED
(Type or Print)

(First)

(Middle)

(Last)

JOHN

W

SEWELL

5. SEX

Male

6. COLOR OR
RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

Married

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

Ret.

10b. KIND OF BUSINESS
OR INDUSTRY

Gov. Employee

8. DATE OF BIRTH

August 13, 1874

9. AGE last birthday

80

yrs.

MARCH 31

19 55

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

13. FATHER'S NAME

John W. Sewell

14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

Mrs. Rose E. Sewell-Wife- same as # 2

INTERVAL BETWEEN
ONSET AND DEATH

??

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A)

bilateral pulmonary tuberculosis

ANTECEDENT CAUSE(S)

DUE TO

DISEASES OR CONDITIONS, IF ANY,

(B)

GIVING RISE TO THE ABOVE CAUSE

DUE TO

STATING UNDERLYING CAUSE LAST.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING

TO THE DEATH BUT NOT RELATED TO THE

DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO

8

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
M. While at work Not while at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/29/54, 19....., to 3/31/55, 19....., that I last saw the deceased

alive on 3/30/55 19....., and that death occurred at 10:40PM, from the causes and on the date stated above.
SIGNATURE: *J. Borrelli* ADDRESS (Street, city, town, state) DATE SIGNED

4/1/55

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

Burial

DATE THEREOF

April 4, 1955

NAME OF CEMETERY OR CREMATORI

Cedar Bluff Cemetery

LOCATION (City, town, or county)

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

J. Borrelli

25. FUNERAL DIRECTOR'S SIGNATURE

HOPPING FUNERAL HOME

ADDRESS

Annapolis, Maryland

DATE April 4, 1955

ANNAPOULIS, MD

17 8

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02283

2256 CERTIFICATE OF DEATH

Item 9, FilmG180 4-20-55 et

Reg. Dist. No. ... 21

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY ANNA Polis (If rural give location)
AA Co 10 HOSPITAL OR INSTITUTION OR STREET ADDRESS	90 CALVERT ST	STREET ADDRESS	90 CALVERT ST 10
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
(First)	(Middle)	(Last)	3 7th 1955
5. SEX Female Colored	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH Married 10-23-1905 65 10 49 yrs.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday IF UNDER 1 YEAR Months Days Hours Min.	
Housewife			
13. FATHER'S NAME WALTER STEVENS		14. MOTHER'S MAIDEN NAME ELEANOR BATSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO	
17. INFORMANT & ADDRESS Eleanor Johnson 90 Calvert St		18. MEDICAL CERTIFICATION Arterio sclerotic Hypertension Cardio renal disease 4 months	
19. DATE OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov 15</u> , 1955, to <u>Nov 9</u> , 1955, that I last saw the deceased alive on <u>Nov 15</u> , 1955, and that death occurred at <u>11:15 A.M.</u> from the causes and on the date stated above SIGNATURE <u>John Reesee II</u> ADDRESS <u>108 Washington St</u> DATE SIGNED <u>3/9/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3-12-55	
24. REC'D BY REGISTRAR		NAME OF CEMETERY OR CREMATORIAL SWAY HILL	
REGISTRAR'S SIGNATURE An Hedrich		LOCATION (City, town, or county) ANNAPOLIS MD	
DATE 3-10-55		25. FUNERAL DIRECTOR'S SIGNATURE William Reesee II 108 Washington St ANNAPOLIS, MD	

14.0000
day

14.0000

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02284

2257 CERTIFICATE OF DEATH

Reg. Dist. No. 21

Item 11, File 179 3-18-55 et

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY A.A. CO CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN Annapolis, Md.		MARYLAND LENGTH OF STAY (In this place) STATE Md. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1316 Bay Ridge Ave.		STREET ADDRESS (If rural give location) 1316 Bay Ridge Ave.	
3. NAME OF DECEASED (First) JOHN (Middle) E. (Type or Print)		4. DATE (Month) OF DEATH 3 7 1955 (Day) (Year)	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH July 20, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Woodwork		10b. KIND OF BUSINESS OR INDUSTRY Cabinet maker	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME John A. Stokes		14. MOTHER'S MAIDEN NAME Mary Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 4	17. INFORMANT & ADDRESS Richard Stokes #2
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
42. IMMEDIATE CAUSE (A) Cerebral Vascular Accident ANTECEDENT CAUSES (B) DUE TO Arterio-venous fistula DISEASES OR CONDITIONS, IF ANY, (B) DUE TO Arterio-venous fistula GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)		3 days	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Burns & post op. of arterio-venous fistula		yes	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 31/3/1955, to 31/7/1955, that I last saw the deceased alive on 31/6/1955, and that death occurred at 11:15 P.M., from the causes and on the date stated above.			
SIGNATURE		ADDRESS (Street, city, town, state)	
23. "BURIAL, CREMATION, REMOVAL" (SPECIFY) Burial		DATE SIGNED 3/8/1955	
DATE THEREOF 3/10/55		NAME OF CEMETERY OR CREMATORIAL Cedar Bluff	
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	
DATE March 9, 1955		John M. Taylor and Sons Annapolis, Md.	

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be used for use as a burial transit permit.

VS AISC 1-55 10A

UNITED STATES

1940

2301 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY Anne Arundel MARYLAND
 CITY (If outside corporate limits, write RURAL or and give nearest town) LENGTH OF STAY
 TOWN Pasadena (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS -- Route 1, Box 372

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY A.A.
 CITY (If outside corporate limits, write RURAL and give nearest town)
 TOWN Pasadena

STREET ADDRESS (If rural give location) Route 1, Box 372

3. NAME OF DECEASED:
(First) (Middle) (Last)

JAMES P. STRONG, Sr.

4. DATE OF DEATH: Mar. 1, 1955

(Type or Print)

5. SEX: 6. COLOR OR RACE: 7. SINGLE, MARRIED, WIDOWED, DIVORCED, 8. DATE OF BIRTH: 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS
 male white (Specify): married Sept. 24, 1885 69 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): 10b. KIND OF BUSINESS OR INDUSTRY: 11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

Earl R. Strong

14. MOTHER'S MAIDEN NAME:

Anne Phillips

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS:

Mrs. Carrie C. Strong - Pasadena, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

42.1
Immediate cause

(a) Acute coronary thrombosis

Interval Between
Onset And Death

8 hours.

Antecedent causes(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Coronary insufficiency

5 years

(c)

generalized arthritis

3 years

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify)
SUICIDE
HOMICIDE

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURY m. INJURY OCCURRED
White at Work Not White At Work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 5, 1954, to March 1, 1955, that I last saw the deceased alive on Feb. 28., 1955, and that death occurred at 2:15 A.M., from the causes and on the date stated above.
 SIGNATURE (Degree or title) ADDRESS DATE SIGNED
 R.M. McLaughlin, M.D. Pasadena, Md. March 1, 1955

23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)
 REMOVAL (Specify) 3/4/55 Loudon Park Cem. Balto., Md.

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS
 REGISTRAR 3-2-55 Rev. Frederick J. Dickner & Sons
 Date Balto. 17, Md.



INSTRUCTIONS

TO ATTENDING PHYSICIAN-OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 4-55 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2392

02286

CERTIFICATE OF DEATH

Reg. Dist. No. *18*

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS	Anne Arundel Maryland Crownsville Crownsville State Hospital	MARYLAND LENGTH OF STAY (in this place) 34 yrs. 4 mos. 9 days	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OWN STREET ADDRESS	Maryland Baltimore City Baltimore City 31-1-4
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)		
(First) Mamie		(Middle)	(Last) Taylor	OF DEATH 3 5 1955
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 1887?	9. AGE last birthday 67? yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY - - -	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Jerry Taylor		14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk.		16. SOCIAL SECURITY NO. Unk.	17. INFORMANT & ADDRESS Hospital Records	
18. MEDICAL CERTIFICATION				
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 443X IMMEDIATE CAUSE (A) Chronic Myocarditis ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Hypertensive arteriosclerosis GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1/21 1948 to 3/5 1955, that I last saw the deceased alive on 3/5 1955, and that death occurred at 12:35 PM, from the causes and on the date stated above. SIGNATURE <i>John E. Eickert</i> ADDRESS (Street, city, town, state) DATE SIGNED Crownsville, Md. 3/5/55				
23. BURIAL, Cremation, Removal (Specify)		DATE THEREOF 3/17/55	NAME OF CEMETERY OR CREMATORIUM Crownsville State Hospital	LOCATION (City, town, or county) (State) Crownsville, Md.
24. REC'D BY REGISTRAR DATE 3-17-55		REGISTRAR'S SIGNATURE <i>John E. Eickert</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Crownsville, Md.	

BUREAU V. S.



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained for use as a burial transit permit.

VS AFSC 155 10M

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

23-3

02287

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
CITY OR TOWN		Anne Arundel Crownsville		MARYLAND		Maryland Baltimore City	
CITY OR TOWN				LENGTH OF STAY (in this place)		CITY OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Crownsville State Hospital		16 yrs. 9mos.		Baltimore City	
				STREET ADDRESS		(If rural give location)	
				1507 N. Calhoun Street			
3. NAME OF DECEASED (First) Rufus				(Middle) Taylor		4. DATE (Month) (Day) (Year) 3 2 1955	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	Negro	Divorced	1892?	62?	Months	Days	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
Laborer			Unknown		Maryland		
13. FATHER'S NAME John Taylor				14. MOTHER'S MAIDEN NAME Delia Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
Unk.				Unk.		Hospital Records	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4-2-1 IMMEDIATE CAUSE (A) Pulmonary edema							
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Known to us since GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) 12/26/54							
Cardio-vascular Disease							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
-		-					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)	
-		-		-		-	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		-	
-		-		-		-	
22. I hereby certify that I attended the deceased from 1/21, 1948, to 3/2, 1955, that I last saw the deceased alive on 3/2, 1955, and that death occurred at 4:15 a.m., from the causes and on the date stated above.							
SIGNATURE <i>R. Peuler, M.D.</i> ADDRESS (Street, city, town, state) <i>Crownsville, Md.</i> DATE SIGNED <i>3/2/55</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>		DATE THEREOF <i>3/1/55</i>		NAME OF CEMETERY OR CREMATORIUM <i>University Hospital</i>		LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
24. REC'D BY REGISTRAR DATE 3-7-55		REGISTRAR'S SIGNATURE <i>Katherine M. Joyce</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Hensley</i>		ADDRESS <i>1100 E. 33rd Street</i>	

1/20/07/00

01 35"

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No.

1. PLACE OF DEATH:

COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWN Annapolis, MdMARYLAND
LENGTH OF STAY
(in this place)

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Anne Arundel

CITY (If outside corporate limits write RURAL and give nearest town)
OR
TOWN Wardour Annapolis MdSTREET
ADDRESS

(If rural, give location)

208 Norwood Rd

3. NAME OF
DECEASED:
(First) (Middle) (Last)

4. SEX:

6. COLOR OR
RACE:7. SINGLE, MARRIED,
WIDOWED, DIVORCED.
(Specify): widow

8. DATE OF BIRTH:

10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired):10b. KIND OF BUSINESS OR
INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT
COUNTRY:

Housewife

Urbana Ohio

U.S.A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

no

16. SOCIAL SECURITY NO.:

None

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

493
Immediate cause

(a) DUE TO

Antecedent cause(s)

(b) DUE TO

Diseases or conditions, if any,

giving rise to the above cause

DUE TO

stating underlying cause last

(c)

Fall in her home

Pneumonia

Fracture left hip

Senility

Feb 8, 1955

Communited intertrochanteric fracture left hip

20. AUTOPSY?

Yes No

21a. EXTERNAL CAUSE WAS

PRIMARY OR CONTRIBUTING

CAUSE OF DEATH.

21b. PLACE (Home, farm, factory,
OF street, office bldg., etc.)

INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)

OF INJURY

21e. INJURY OCCURRED

While at work Not while at work at work

21f. HOW DID INJURY OCCUR?

Slipped going to bath

22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , andfind that death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined cause .

SIGNATURE

M. D.

CHIEF MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

ASSISTANT MEDICAL EXAM.

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CEMETORY

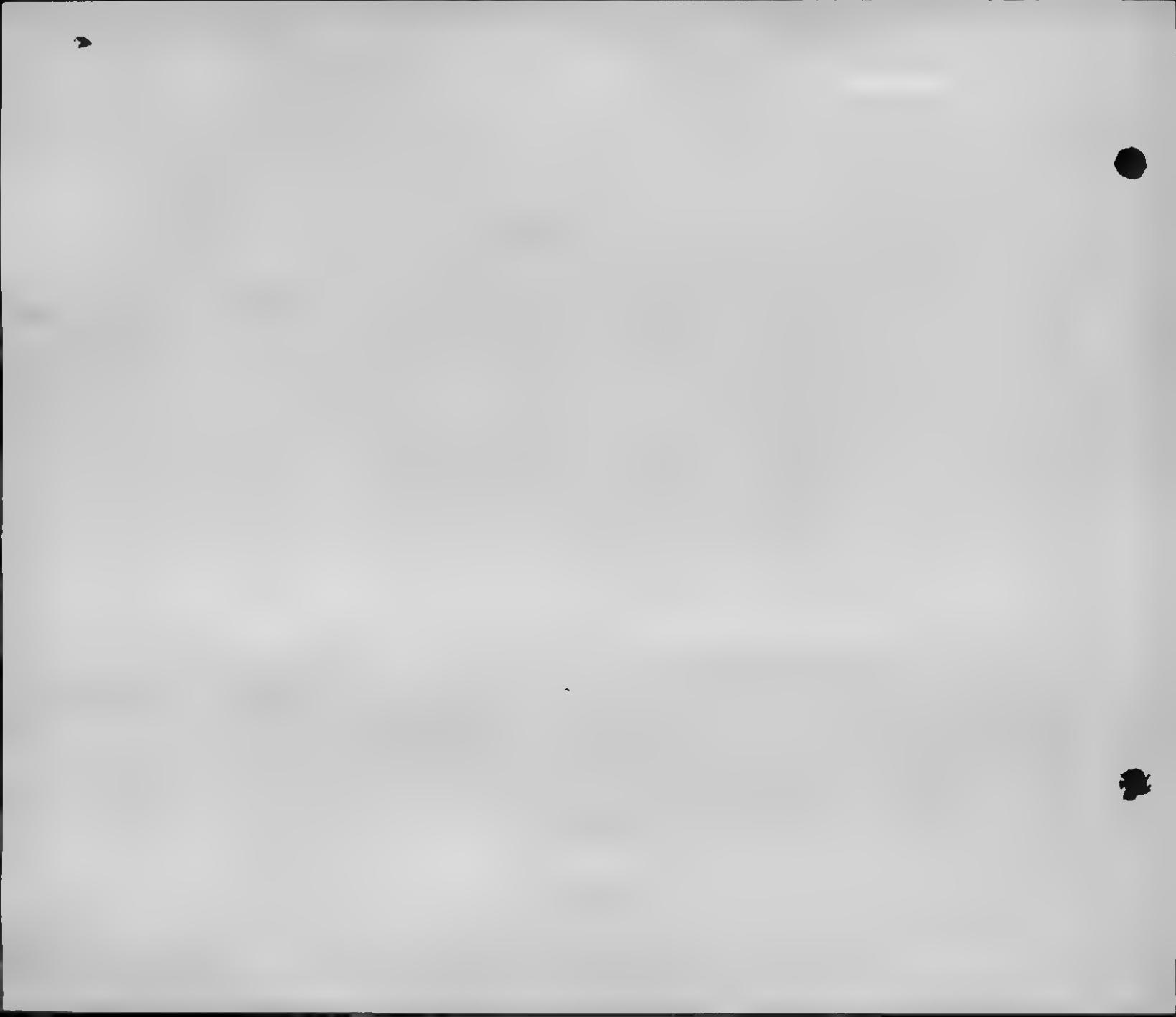
LOCATION (City, town, or county)

(State)

REG.

DATE REC'D BY LOCAL

REG.



2324

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Anne Arundel MARYLAND CITY (If outside corporate limits, write RURAL or and give nearest town) TOWN Pasadena		STATE Maryland COUNTY A A CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Pasadena STREET ADDRESS (If rural give location) 1 Doris Ave.	
3. NAME OF DECEASED: (First) William (Middle) (Last) Thomson (Type or Print)		4. DATE OF DEATH: March 12 1955 (Month) (Day) (Year)	
5. SEX: Male COLOR OR RACE: White 6. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH: 8/23/1903 9. AGE last birthday: 51 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Salesman		10b. KIND OF BUSINESS OR INDUSTRY: Grocery	
11. BIRTHPLACE (State or foreign country): Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Walter Thomson		14. MOTHER'S MAIDEN NAME: M.C. McCracken	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) -----		16. SOCIAL SECURITY NO.: 716-07-5865 17. INFORMANT & ADDRESS: Mary T. Thomson 1 Doris Ave. Pasadena Md.	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) ... Carcinoma of stomach Antecedent causes (s) (b) ... Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) ... DUE TO			
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) OF INJURY	(Day) m.	INJURY OCCURRED While at Work <input type="checkbox"/> At Work <input type="checkbox"/>	HOW DID INJURY OCCUR? ADDRESS
22. I hereby certify that I attended the deceased from Oct. 2, 1954, to Mar. 12, 1955, that I last saw the deceased alive on Mar. 12, 1955, and that death occurred at 8:25 a.m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED			
23. BURIAL, CREMATION, DATE THEREOF REMOVAL (Specify) Burial 3/12/55		NAME OF CEMETERY OR CREMATORIUM Moreland Memorial Cem	LOCATION (City, town, or county) Baltimore (State)
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REGISTRAR		24. FUNERAL DIRECTOR John A. Moran 3000 E. Falto. St. ADDRESS See Edwin J. Sterling	



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained for use as a burial transit permit.

VS A15C I-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2396

CERTIFICATE OF DEATH

02291
24

Reg. Dist. No.

1. PLACE OF DEATH Anne ARUNDEL COUNTY CITY (If outside corporate limits, write RURAL OR TOWN) GLEN BURNIE HOSPITAL OR INSTITUTION OR STREET ADDRESS PLAZA MANOR CONVALESCENT HOME, Route 2 Box 376A		2. USUAL RESIDENCE (HOME) OF DECEASED MARYLAND LENGTH OF STAY (in this place) 2 months	
3. NAME OF DECEASED (Type or Print) BESSIE		4. DATE OF DEATH (Month) (Day) (Year) March 8 1955	
5. SEX F	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH July 14, 1892
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BURIAL PLACE (State or foreign country) Baltimore Md
13. FATHER'S NAME William Bundy		14. MOTHER'S MAIDEN NAME Emma Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS Albert Bundy		18. MEDICAL CERTIFICATION Septicemia, Kachexia. Diabetes mellitus and multiple abscesses of skin & gangrene	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from... 1/15 1955, to... 3/5 1955, that I last saw the deceased alive on... 3/5 1955, and that death occurred at 10P M, from the causes and on the date stated above. SIGNATURE Joseph Taylor M.D.		21f. WHERE DID INJURY OCCUR? (City or town) (County) (State) 102 Baltimore-Harford Blvd. 3/8/1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Funeral		24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE C. C. Hedrick	
DATE 3/11/55		DATE THEREOF March 11/55	
25. FUNERAL DIRECTOR'S SIGNATURE Mrs. Robert A. Elliott		ADDRESS 1129 S. Carolina St.	

20 292.1, 1

20 292.1, 1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2259

CERTIFICATE OF DEATH

02292
21

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Anne Arundel Annapolis	MARYLAND LENGTH OF STAY (in this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Riva
13. HOSPITAL OR INSTITUTION OR STREET ADDRESS		14. STREET ADDRESS (If rural give location)	
Anne Arundel General Hospital		Sylvan Shores	
3. NAME OF DECEASED (First) (Type or Print)		4. DATE (Month) OF DEATH MARCH 11 (Day) (Year) 19 55	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH December 17, 1936
9. AGE last birthday 18 yr.	10. KIND OF BUSINESS OR INDUSTRY Dentist attendant	11. BIRTHPLACE (State or foreign country) Worcester, Massachusetts	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Dr. John N. Wilson	14. MOTHER'S MAIDEN NAME Wilma V. Vierbucken		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. 212-34-1823	17. INFORMANT & ADDRESS Mrs Wilma Wilson- Mother- same as # 2	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 541.0 IMMEDIATE CAUSE (A) <i>Disseminated Hemolytic Anemia</i> ANTECEDENT CAUSE(S) DUE TO <i>Perforated Peptic Ulcer</i> DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 21f. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from... <u>3-7</u> , 19 <u>55</u> , to <u>3-11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-11-55</u> , 19 <u>55</u> , and that death occurred at <u>7:45A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Edward J. Beck</u> M.D. ADDRESS (Street, city, town, state) <u>410 Southgate Ave Annapolis</u> DATE SIGNED <u>3/12/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF <u>3-14-55</u>	NAME OF CEMETERY OR CREMATORIUM <u>New Cathedral Cemetery</u>	LOCATION (City, town, or county) <u>Baltimore, Maryland</u>
24. REC'D BY REGISTRAR DATE <u>March 14, 1955</u>	REGISTRAR'S SIGNATURE <u>J. O'Donnell</u>	25. FUNERAL DIRECTOR'S SIGNATURE B.L. Hopping and Son ADDRESS <u>Annapolis, Md.</u>	

TO ATTENDING PHYSICIAN OR HOSPITAL The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR The law requires that the death certificate be filed with the registrar within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained for use as a burial transit permit.

VS AISC 1-55 10W
The bottom copy may be retained by the hospital or attending physician.

BUKEAU Y.

MAR 15 1955

RECEIVED

02293

2307

CERTIFICATE OF DEATH

Reg. Dist. No

28

214

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

10. FUNERAL DIRECTOR: The law requires that the death certificate be

Y5 A15C 1.55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY OR TOWN		Anne Arundel (If outside corporate limits, write RURAL and give nearest town)		MARYLAND LENGTH OF STAY (In this place)		Maryland CITY OR TOWN	
X HOSPITAL INSTITUTION OR STREET ADDRESS		Crownsville		55 days		Baltimore Cockeysville (If rural give location)	
10 Crownsville State Hospital				STREET ADDRESS		Almshouse	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
James Henry Winder				March 26 1955			
5. SEX Male		6. COLOR OR RACE Negro		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) separated		8. DATE OF BIRTH Unk.	
9. AGE last birthday 70? yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Robert Winder		14. MOTHER'S MAIDEN NAME Frances			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT & ADDRESS Hospital Records			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 025X IMMEDIATE CAUSE (A) Lobar Pneumonia 2 days known to us ANTECEDENT CAUSE(S) DUE TO (B) C.N.S. Syphilis, Meningoencephalitis since 2/1/55 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2/1., 1955, to 3/26., 1955, that I last saw the deceased alive on 3/26., 1955, and that death occurred at 2:00 PM, from the causes and on the date stated above. SIGNATURE (L. Benedict, MD) ADDRESS (Street, city, town, state) DATE SIGNED Crownsville, Md. 3/26/55							
23. BURIAL, Cremation, or Burial (Specify)		DATE THEREOF 3/30/55		NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery, Baltimore, Md.		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR Burial		REGISTRAR'S SIGNATURE Katherine M. Joyce		25. FUNERAL DIRECTOR'S SIGNATURE McC. J. C. Bradley, W. Cuddeback		ADDRESS	
DATE March 28, 1955							

BUREAU V. S.
D.M.R. - 125
BUREAU V. S.

INSTRUCTIONS

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2398

02294

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	A. A.	MARYLAND	STATE Md. COUNTY
CITY (If outside corporate limits, write RURAL OR give nearest town)	LENGTH OF STAY (In this place)	TOWN	CITY (If outside corporate limits, write RURAL and give nearest town)
X Millersville, Md.	8 months	TOWN	Baltimore 31 3401-4
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)		
90 SANN's Nursing Home	348 Balloou Court		
3. NAME OF DECEASED (Type or Print)	(First) Bertha	(Middle)	(Last) WOLF
5. SEX F	6. COLOR OR RACE W	7. SPOUSE STATUS WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Feb 5, 1877
9. AGE last birthday 78 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY OWN Home	12. BIRTHPLACE (State or foreign country) Baltimore, Md. COUNTRY? U.S.A.
13. FATHER'S NAME William Brandt	14. MOTHER'S MAIDEN NAME (UNK)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS HARRY C. WOLF, SR. Glen Burnie, Md.	
18. MEDICAL CERTIFICATION IMMEDIATE CAUSE 443X Hypertension cardio-vascular disease ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (A) (B) (C)		INTERVAL BETWEEN ONSET AND DEATH + 8 months.	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July 8, 1952, to March 7, 1955, that I last saw the deceased alive on March 4, 1955, and that death occurred at 9 P.M., from the causes and on the date stated above. SIGNATURE Keystone & Bunker, MD. M.D. ADDRESS (Street, city, town, state) DATE SIGNED 3/8/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	DATE THEREOF 3/10/55	NAME OF CEMETERY OR CREMATORIUM GLEN HAVEN	LOCATION (City, town, or county) GLEN BURNIE, MD (State)
24. REC'D BY REGISTRAR DATE 3-10-55	REGISTRAR'S SIGNATURE KM Joyce	25. FUNERAL DIRECTOR'S SIGNATURE HOPP JAGG & KIRKLEY ADDRESS GLEN BURNIE, MD	

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

CERTIFICATE OF SERVICE

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

BUREAU V. S.

MAR 14 1968

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2309

02295

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH

COUNTY

A A

MARYLAND

CITY (If outside corporate limits, write RURAL
OR
TOWN
end give nearest town)

SEVERN (RURAL)

LENGTH OF STAY
(In this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS3. NAME OF
DECEASED
(Type or Print)

Herbert

(First) (Middle)

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

COUNTY

Md. A A

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN

SEVERN (Rural)

STREET
ADDRESS

Quarterfield Rd.

(If rural give location)

4. SEX

M

6. COLOR OR
RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

8. DATE OF BIRTH

Oct. 13, 1886

9. AGE last birthday

68 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)10b. KIND OF BUSINESS
OR INDUSTRY

Railroad

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME

AUGUST Wolf

14. MOTHER'S MAIDEN NAME

Elizabeth Nickolson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unk.) (If Yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

213-03-6993

17. INFORMANT & ADDRESS

Roy Wolf, Severn, Md.

18. MEDICAL CERTIFICATION

IMMEDIATE CAUSE

(A)

Chronic Mitral Insufficiency

INTERVAL BETWEEN
ONSET AND DEATH

+ 3 years.

ANTECEDENT CAUSE(S) DUE TO

(B)

Chronic Interstitial nephritis

+ 3 years

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(C)

19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY
YES NO

(State)

OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
M. While el work Not while el work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January 19, 1951, to March 11, 1955, that I last saw the deceased

alive on March 10, 1955, and that death occurred at 7 A.M. from the causes and on the date stated above.

SIGNATURE

Herbert Wolf

ADDRESS (Street, city, town, state)

DATE SIGNED

3/12/55

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county)

(State)

Burial

3/14/55

Friendship

A.A. Co.

CEMETEDE DE GRAN

BUREAU V. S.

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RECEIVED